DEPARTMENT OF DEFENSE

T R I C A R E
MANAGEMENT ACTIVITY

TRICARE NEXT GENERATION INFORMATION TECHNOLOGY BRIEFING

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TRANSCRIPT OF TAPE RECORDED BRIEFING

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[The tape recorded briefing as set forth on page one is transcribed as follows:]

MR. MEEKER: Good afternoon, everyone, and welcome. I guess it's pretty obvious what we're here for, but this is the Tricare Next Generation Information Technology Pre-proposal Briefing.

Just to clarify, this isn't a pre-proposal conference. We had a pre-proposal conference for one of our RFPs, or health care RFPs a few weeks ago.

The pre-proposal conference for our dual eligible claims processing contract will be tomorrow morning. This is simply an information technology briefing, although we are running it quite the same way.

We are doing this because we understand that there are people who need more information about our systems, and we would like to give you that information.

As you can see, on my beginning slide, the two RFP numbers are on there. Six and seven, which as I mentioned just a moment ago, are health care and are dual eligible claims processing RFPs.

The purpose for today is to familiarize and update

potential offerors regarding our various IT systems in use. This list includes a DEERS system, which is our enrollment and eligibility system, Tricare Online, our composite healthcare system, duplicate claim system, and our IT security. Each of these will have its own presentation, and we'll be able to answer questions after those presentations, if you have questions.

I'd like to put a few ground rules forward. First of all I should probably tell you who I am. My name is John Meeker, and I'm the Director of Contracts for Tricare, and I'm up here to make sure that everything goes well, and that we are fair to all of our offerors, and make sure that this does run smoothly. That's why we have some ground rules.

Our ground rules are simple, actually. We want you to ask questions, and we want you to ask them however you want to ask them. If you want to ask them orally, please go to the microphones. There's two microphones on either side of the room that you can feel free to go to after the presentations and ask your questions, or you can also submit your questions in writing.

We will have Karen, who's in the back of the room right there, if you need something to write on, please flag her down and she'll give you something, and you can submit your

questions that way.

Every answer that we can give, we will give verbally at the end of the presentation when they're asked. If we can't answer the question today, because we need to do further research or make sure that we give you a clear answer, we will ask that you give us a little bit of time.

We will post all of those answers on the website, regardless of whether you submit them in writing or orally, or whether we answer them today or not. All answers will be posted to the websites, and they will be posted to both websites, the dual eligible website, and the health care website. They're both at the same place, and we'll get to that in a moment.

Please remember that no answer is final until it's posted. We may give you an answer today that we think might be more clearly answered after we get back to our office. So we ask that you not consider them final until posted, although every answer you get today should be 99 percent sure.

To continue our ground rules, and wrap up my part of this, if an answer does change any requirement in either one of the RFPs, and it's unlikely that will happen, but if it does, it will require an amendment to the RFP. An amendment is not official and a change is not official until a contracting

officer has issued an amendment against the RFP. So even if the answer is on the website, if it actually has a requirements change, that will not be done until the change is issued through an amendment.

After the conference, if you're on your way home or anywhere else, for that matter, and you think of another question, please go to the RFP website, and submit those questions through the appropriate contracting officer. The contracting officers I have listed up here are Bruce Mitterer for the Health Care RFP, and Doris Navarro, for the dual-eligible RFP.

Underneath that, you can also see the website. I think you probably all have been there, or you wouldn't be here. So I think that's probably not news to anyone. You'll see that website repeated, again, throughout the day. If you have any questions, or you need any information, please submit those questions to that website, and we'll get answers to those questions as quickly as we can.

Are there any questions with regard to anything I've said? No? Okay. Since there are no questions, I'd like to introduce the Chief Information Officer for MHS, Military Health System and Tricare. He is going to MC the rest of the day. I'll be here to help if we have any questions, but he and

his panel presenters, I'm sure, will be able to answer all of your questions, and that's Mr. James Reardon.

MR. REARDON: Thank you. Let me thank each and every one of your for coming here today. On behalf of the Health Affairs and Tricare Management Activity, it's a pleasure to have you here.

To show you the level of interest that we have, I'd like to introduce the VIPs and the senior leadership who are attending both from health affairs and from the Tricare Health Management.

We have Mr. Ed Wyatt, who's the Principal Deputy Assistant Secretary of Defense. We have Major General Nancy Adams, who is Special Advisor to the Assistant Secretary of Defense Health Affairs. We have Rear Admiral Tom Carrato, who is the Deputy Assistant Secretary for Health Planning Administration. We have the Director of Operations, Mr. Brian Rubin, and we have the Director of Acquisition Management in the TMA, which is Mr. Ron Richards. For their attendance here and their willingness to spend the afternoon I'd like to thank them for their time and their dedication to this very important event. It's a pleasure for me to be able to MC the event.

The way we are going to organize this day is to have the briefers present their programs and then answer any

questions after each briefing, and to insure that, what we have done is bring in experts on each of these systems from around the United States. Your questions should be directed to the presenter who will either answer them or ask one of hte panel members to address them.

First, we will be doing a briefing on the Defense Enrollment Eligibility Reporting System known as DEERS. We use this in the medical community frequently for eligibility checking. This is the personnel database for the Department of Defense. So there's just much more in the system than only what meets the needs of the medical community.

Let me just introduce the people who are here today, who will be answering questions. We have Janine Groth, who is the Program Manager, Medical Project at DEERS, at the Defense Manpower Center.

We have Mr. Robert Brandewie, who is the senior executive for DEERS. He is a member of the Senior Executive Service and is the Deputy Director of the Defense Manpower Data Center.

We have Ms. Ginger Bassett, who is the Clinical Assistant Director from the DEERS program.

(Recorder malfunction. Inaudible.)

MR. BRANDEWIE: ...and is the envy of all (inaudible)

And what we've tried to do in this presentation, (inaudible)

I think you'll find this interesting. And what we've tried to do with this presentation, is we realize we really have different audiences.

We have offerors who are current Tricare contractors. We have offerors who are perhaps new to the Military Health Care System. We have government people, and of course, we have a group of senior executives who I would love to brief on what DEERS does.

And I'm hoping that I can give all of you pieces of information that you didn't know before about DEERS, and you might think this is odd, but especially the offerors who are current Tricare contractors, because the DEERS you're going to see is really the DEERS you're not used to dealing with in the current system.

We're talking about what we call "new DEERS," and it's a new way of thinking and a new way of presenting to you the kind of business services that come through DEERS.

So in order to do this, principally myself, and then Janine, are going to go through a series of slides that explains kind of what's shown on the agenda.

We're going to give you a little bit of a history lesson. I'm also going to try and talk a little about Military

Personnel and how Military Personnel works.

At the root of it, DEERS is a personnel system, and it feeds off of personnel systems throughout DoD. So I'm going to talk about that.

We're going to talk about the architecture and the infrastructure that we built to support the MHS with DEERS; talk a little bit about our concepts. What our concept is of a "person", a "beneficiary," a "family member." Then we're going to kind of drill down and tell you how we identify those people, and then how your systems are going to interact, using those identifiers.

Finally, I'm going to turn it over to Janine, and we're going to drill down even further, and tell you about all the business processes we support and how we support them. So that's essentially the agenda.

Let me talk about the mission. The Department of Defense, of course, is a big, complex animal. Its size is, I think, a surprise to a lot of people who don't understand its various tentacles.

It does have a different approach to HR Management. There is no centralized HR Management within the Department of Defense. It's very much split out.

In the late '70s, early '80s, the Department said,

"We don't know how many people work for us. We don't know how many people are in our Medical Care System. We need to gather that together and have a corporate view of the personnel."

That was essentially the mission that was laid on DEERS. We were to take the four principal pillars of personnel within the Department: the active duty, our reservists, our military retirees, and our civilian population; gather them all together into one place and build them into a benefits management system, and if you will, a corporate HR system.

In the early '80s, this was primarily a job of taking tapes back and forth, working with main frames, and you know, matching and merging, and all those kinds of things we used to do in the early '80s.

Now, it's a much more electronic business, but the basic business of DEERS is still the same. It is to pull together all of our, what we call, sponsor community into one place, and then break all the ties. Make sure that one person is accounted for in one bucket, or at least to call out the affiliations for everybody.

A secondary mission was, "Okay, now that you've got all the sponsors in one place at one time, let's add in the family members." So we will collect information on all the eligible family members of that sponsor population.

Once that was done, you have a database that not only can drive benefits management, but you also have a data base --

[Speaking away from microphone. Some remarks not recorded.]

MR. BRANDEWIE: It all started a long time ago. And I've kind of referred to that already. The late '70s, the idea was, "Hey, we need a corporate look, guys."

In '82, it first became operational. We got to the point where we were confident enough in the information we were getting from the services, and from the feeder system, that the DEERS -- that we set up a system -- the program office, interestingly enough, started in health affairs, and then migrated to DMDC, which is essentially a personnel community, essentially a personnel function, the idea being it's up to personnel to tell the Department and our contractors who is eligible for the benefit, and it's then up to the medical community to take it from there, and actually deliver the health care. So we moved the program office back in 1994.

It became and is, the earliest DoD enterprise system. It's a worldwide system to include RAPIDS for the collection of family member information. It's worldwide. It's in a number of countries.

And it was the first total force system. It had all

those pillars I talked about, active, reserve, civilian and retirees gathered in one place.

One thing I need to make clear is this is just not a DoD system. This is a uniform services system. So it includes three elements outside the DoD: NOAAA, Coast Guard, and Public Health Service. So it's a uniform services system, and it's fed by personnel systems on all the uniformed services.

Let me go over the components that I think I'd like to put into your mind as the major components in the system. DEERS itself is really a database. It's an oracle relational database first fielded in 1999.

It's a fairly complex data base. It consists of a central core, which we call a Person Data Repository, and then satellite databases that contain information that is functionally different, but it's closely linked with the Person Data Repository.

It might surprise you to know how many records are in here; 23 million people in DEERS. That isn't really records. That's people.

And obviously they're not all eligible for military health care, before anyone faints away on me. A lot of them are there for other reasons. They have educational benefits, for example, or they're recipients of one of our other benefits

programs.

So that 23 million records is fed by feeder systems in the services. There's about 75 feeder systems that together constitute DEERS.

Since we are a realtime system, a realtime relational database, we take updates and apply them as we get them. We can take realtime updates. All of our family member updates are realtime.

Our civilian population is going towards realtime. Not quite there yet. Unfortunately our military populations are not there yet. And the reason is, they're underlying systems are still Legacy, for the most part, and they're not up to a realtime feed to DEERS.

So DEERS is database, it's relational, oracle based, realtime system; can take realtime feeds. Essentially the value proposition that we've made with the services is, as fast as you can give it to us, we will take it and apply it to DEERS.

There are two applications that you need to know about. One that I mentioned already, which is called RAPIDS. And for those of you who are harboring the allusion that we don't like acronyms, there are three of them up there that are kind of doozies. DEERS, of course, Defense Enrollment

Eligibility Reporting; RAPIDS is Realtime Automated Personnel Identification System. And if you don't think they sat around burning the midnight oil to think that one up.

RAPIDS is the ID card application. It issues ID cards, and as I mentioned, those are important pieces of plastic, but it also is a source for entering family member information. And later on, I've got a slide that shows you how we validate the addition of family members into the military system, and how we assign benefits to it.

Okay. So RAPIDS has two important functions. One is to issue that identification card, and the second is, to collect information about family members in a very ordered and structured way.

The third box up there represents DOES. And DOES is the online enrollment system that we fielded in June of 2001.

DOES implements what we call national enrollment. And we will talk about how national enrollment works in DEERS and what information is up there later on in the briefing.

DOES is the application that is pushed out to the managed care support contractors, and to our military treatment facilities to collect enrollment information from beneficiaries.

If you think of those three major boxes, as we go

through the briefing, I think you'll have a better feel for how that all lays out, and how the information interrelates, because I've got to warn you, some of it gets kind of complicated.

There's an infrastructure that supports this. And here's another key concept, and that is that DEERS is a network asset to the entire department. And the entire department is spread out all over the place, as everybody kind of well knows.

DEERS itself has about 30,000 units. These are people who are registered in our system, and they include people in the MTS and people with the Managed Care Support Contractors, as well as people in the services, people in law enforcement, people in personnel, people in the Educational Benefits Administration.

All of these are users of DEERS. We provide them with tool kits so they can view the information, and in fact, take information that they need to get their job done.

We also have what you might call wholesale users of DEERS. These are people who use DEERS as services to drive their business process. And of course medical is certainly in there, but there are lots of other functional communities that are using DEERS information to drive a business process in a wholesale way, with thousands of records being pushed out

there. All of these uses, I think again, are good, because they are mutually reinforcing and improve data quality.

RAPIDS, which is where we collect our family information, has about 2,000 work stations and 900 sites in 23 countries. So it really doesn't matter where you're stationed. I mean, there's one in Diego Garcia, there's on in Riyadh.

No matter where you're stationed, you can get your family members into DEERS, and you can manage and maintain your DEERS records through the RAPIDS system. Not only can you do things with the family members, but we also allow the military members to update their records to some extent at a RAPIDS station.

Finally, DOES. DOES has about 1,200 work stations, and about 50 sites. That's our enrollment capture application. And so that's the infrastructure.

I skipped over one thing, and that was the transaction volume. If I were showing you this slide a year ago, that transaction volume would be about 1.1 million transactions a day. We're up to 2.2 million transactions a day. I would say about 80 percent of those are medical transactions. They're coverage inquiries and claims. That's a fairly high transaction load.

It's not part of this briefing, but at some point, we

need to reassure you that we have an infrastructure, a set of servers and a support infrastructure at essentially two sites that are going to support this transaction load. And we've worked very hard to make that a 24 by 7 operation, and we're making big improvements within the next six to nine months to make sure we can service that infrastructure.

DEERS has a special set of services that it provides to Tricare. And if I could direct your attention not so much to the upper right-hand corner, but in the upper left. It is meant to show you all the feeder systems. There are about 75 feeder systems that DEERS uses to collect information.

I wish I could tell you that all of the feeder systems are of the highest quality. In fact, many of them are a very high quality, but they're stovepipe systems.

So the Army Guard and the Army Active should be talking, and aren't. So when the Army Guard sends us a file, it often contains the same people or some of the same people that the Army actives also claim as members. This is a problem.

This is the essence of where DEERS adds value. That's kind of another concept I wanted to convey to you.

DEERS takes all of these 75 systems, warts and all, and doesn't spit them back to you. It tries to resolve the

issues that come up, either data quality issues, or affiliation issues, and that's the case where the Guard says he's a Guardsman, and the Army active says "No, no, no, we've activated him, and shipped him off," to who knows where. And of course, that dictates different benefit streams. So those 75 feeder systems feed up and create what is the sponsor portion of DEERS.

Our value add is to maintain the interface to the services and break all the ties, and provide a high quality product, where we have done our level best to give you a solid basis of information on each and every sponsor.

Family members come through RAPIDS. National enrollment, which is an important concept as well, is fairly new to the MHS and Tricare, but national enrollment provides new sources of central information on enrollments by members and their families.

We have all of the communications protocols in place to talk to all of the MTFs and the MCSCs. So we're kind of a communication hub. We can talk to the services, we not only get their data electronically, we can kind of understand it. We can understand it, and we can interpret it. So we add value in that world.

Then we're already set up to talk to the MTFs and the

MTSCs. We also have a lot of EDI experience. We like to be, or claim to be, protocol neutral. We don't care what you're talking, we're going to talk to you.

If it's a proprietary transfer record, if it's some of the crazy legacy protocols that we have to talk to the services with, if it's TCPIP transactions, if it's ECEID transactions, if it's HIPAA, if you can name it, we can talk to you with it. And this is the way we increase communications throughout the MHS.

We also have an EDI person ID. We're going to talk about identifiers a little later in the presentation.

We need an unequivocal way to talk about a person. We need an unequivocal way to talk about a beneficiary, we need an unequivocal way to talk about a family member, and we need an unequivocal way to talk about an insurance policy.

All of those identifiers are imbedded in DEERS. We're going to hopefully, with great clarity, lay out how it all works. So DEERS has a special relationship and a special place with Tricare.

We've called out some joint goals with the MHS. These are joint goals in which DEERS can assist and can facilitate, essentially, the goals of the MHS.

One is to establish full portability. The fact is,

people move around a lot in our system. They move, not only geographically, their families move, their families are split.

In that movement, with a regional model was a problem. We want to make seamless, the moving experience for the military members, as far as Tricare is concerned, and we want to use DEERS to do it.

We want to facilitate the kind of one Tricare look. One look to the beneficiary, and one set of common business processes that are subsumed and instantiated into yours.

We also want to make sure that the government takes ownership of key pieces of information. And not only because it's a control issue. And that's probably not even the principal reason, but because we want to be responsible for improving the data quality, and maintaining the data quality of pieces of information. We want it to be basically unequivocal, and we want to provide data as a service, and DEERS as a kind of utility to the MHS.

We want to allow and free up the MTFs and the MCSCs to focus on patient care, and to not worry as much about the administrative aspects. And I say worry about them, because in the next part of the briefing, we're going to talk about some of the complexities involved in this whole process, and why we think it's a good idea for DEERS to solve that.

We extend those goals for T-NEX. So we take those goals for the MHS, and we extend them for T-NEX; provide full benefit portability, increase visibility in the access. That is a clear goal that we have for the next generation of contracts.

We want to be the database of record for eligibility, enrollment, PCM assignment, fee totals, Cat cap and deductibles, okay? So there is a place that you can go and you can get all that information. And it is, one, unequivocal, and two, correct, and three, you can run to the bank with it. Or at least you can hold the government responsible for it. So DEERS wants to be the database of record for those things.

We want to provide a common enrollment platform with a single set of business rules that are well defined, and are available anywhere in the world to any one of our members.

We want to provide person identification services to MHS systems. That means, not only do we want to tell you about a person's enrollment, we want to be able to give you different identifiers based on different input.

If you give us a patient ID, we can give you a social security number, for example. If you give us a beneficiary ID, or a DEERS ID, we can give you back the patient identifier, or SSN.

We want to also serve, not only as an authentication mechanism, but as a person ID service to the MHS. And of course, we want to provide the link between the personnel community and the medical community.

I won't say too much about this slide. These are the elements of portability. The policy, the PCM, information on other health insurance, and then the catastrophic cap, deductible and fee information.

We want to provide eligibility information. How does that happen? Let me briefly go through this slide.

The important thing, and there's really two processes outlined here. One is adding a sponsor to the database. Adding a sponsor to the database, prior to 9/11 a year ago, two years ago, was a not-well-managed process, quite honestly. We had lots of people adding sponsors in.

We have locked that down, in the sense that, the only way to add a sponsor, is through an official confirming record from an independent source. And in the case of DEERS, in almost all cases, it's a personnel file from the military service, or the defense agency, if it's a civilian employee.

So people only get added because their personnel office, in a secure exchange of information, says "That guy works for me." Okay?

It doesn't get added because he shows an ID card, or set of orders, and runs down to a verifying official and says, "I'm in the Army now. Add me to the database." It has to be owned up to by the Army as well. So sponsors only get added through this official confirming record from a secure independent source.

Family members only get added when there is a sponsor already in the database. And family members get added through RAPIDS, which is the ID card application.

They get added when a verifying official uses the procedures that are called out in this instruction. DoD instruction 1000.13 is the bible for entitlements in the Department of Defense. And it lays out for that verifying official, what kinds of documentation he or she needs in order to add a family member.

It involves examination and duplication of essentially primary records like birth certificates and marriage certificates. There's a photo ID requirement, and it's through that process that family members get added.

As people are added, then the rule base -- and DEERS has an independent business rule base -- it then determines the entitlements for each of those people, either the sponsor or the family members.

Just so we're clear, DEERS is a data base, and also outside of it, it's got a rule base. In that rule base, and there are probably a dozen of them, are the business rules that we use to determine, in this case, entitlements.

From entitlements, you get assigned coverage plans, again, out of a rule base. So you have a sponsor, enters the Army, the Army acknowledges him, gets into the database, brings the spouse in, she gets added through RAPIDS.

What we do is code up their entitlements, and based on those entitlements, we assign a coverage plan. The coverage plan examples are on the right.

It's the assigned coverage plans that then determine what enrolled options are available to the members. So when you get delivered -- some members never come to an MCSC, right? They just take what's assigned. They are single guys in the military, and they're assigned direct care, and you never see them. As a managed care support contractor, you'll never see them.

But in the case of family members, then that determination determines, along with a bunch of other things in the rule base, what enrollment options they can pick.

The next slide is an example of just some of the options. Example, an active-duty member, not in a remote area,

and the assigned plans are on the left, and what the selection is on the right.

You might say, as a managed care support contractor not familiar with this, "How in the world can I figure this out?" Well, DOES does that for you. DOES, the application that we developed at enrollment limits the options to only those options that the member can pick.

We're actually -- and this is again part of this idea

I want you to take away -- DEERS is kind of taking some of the complexity in the MHS and managing it for you in a way where we can be held accountable. If Admiral Carrato says, "Hey, wait a minute, that's screwed up. You missed a plan," then that's our fault and we take responsibility for that. But I'm telling you, it's not going to happen.

So that's kind of a brief. Janine is going to go more into enrollment. How am I doing on time? I have about three minutes left.

Let me talk for a second about the PDR, and let me talk for a second about more of the complexity that's inherent in our enterprise, and how DEERS handles that for you. We're going to follow an example through.

I mentioned that DEERS has a PDR, person data

repository, as part of it. That's all about a person. A single record, unequivocal, about a guy, about a person. That person can have multiple affiliations with the Department of Defense, and in fact, many do.

In the example we have here, he happens to be a retired, active-duty guy, who also works as a civil servant. Those affiliations are separate from him as a person. Right?

Him, as a person, he's a single person, he has multiple affiliations. Each of those affiliations have a different benefit set. In the case of a civil servant, he doesn't have a medical benefit, right? Well, unless he's overseas, and then he does have one.

So all of the conditional rules are what we're building into DEERS to help solve this complexity. Single person, multiple affiliations. He has a family member. That family member can have multiple affiliations. It can be his child, but it also could be, for example, a reservist.

So he's an 18-year-old kid, maybe going to school full time, who's also part of the reserves. That gets tracked in DEERS as well.

So that child is also a sponsor in his or her own right, as well as being a child. Those drive different benefit sets.

An important point: in the old system, in Legacy, it was hard to get to a person. It was hard to get to a family member, for example, without knowing a lot about the sponsor. This made this situation, a multiple affiliation, really, really difficult to handle in the Legacy system -- it's still hard to handle in the Legacy system.

In new DEERS, it is handled. Not only do you have all of this relationship information, and we'll tell you how that's kept in the data base, but you can get to everybody.

Everybody's their own person, and we keep the relationship in DEERS, so you now can sort it out. Is this individual acting as a member of this selected reserve, or is this individual giving you a claim as the child of the person that we've identified?

So multiple affiliations for sponsors, and then family members can also have multiple affiliations, but you can get to all of them. And you can get to all of them using primary IDs, like social security numbers, or TINs or FINs, foreign IDs of people who are outside the United States, for example, don't have SSNs. And/or secondary information, like last name and date of birth.

But let me tell you going in, in our Legacy system, last name, date of birth, was used a lot for claims. Don't go

there. Use the identifiers that are going out, because it is hideous in a database this large to worry about last name and date of birth.

NED: in national enrollment, we've talked about a person, we've talked about multiple affiliations, and we've talked about family members. Let's talk about beneficiaries.

In NED, you have information about a beneficiary. And in NED, you have information about the policy that they are entitled to. The enrollment choice that they have. Their assigned entitlements. And then we keep the information on fees, and cat caps and deductibles.

So going back to our example, again, if we look at the family member, right? The kid who's a child, and also a selected reservist, he's two beneficiaries. Right? He has two beneficiary records in NED. Different beneficiary sets.

Those beneficiary sets, I'm sad to say, are also dynamic. In the case of the Department of Defense, we activate reservists all the time.

So that beneficiary set, which contains his entitlements, and enrollment options, and assigned coverages, can change when he's activated. And so we've introduced a time dimension. Right?

So you have a claim now for an individual who was on

active duty, who looks to you today like a reservist. Well, you need to enter the time dimension, and ask "What was the claim for?" This is, again, the things that we handle for you by keeping different segments and time basing our beneficiary records.

We're going to go briefly into identifiers, because Janine is going to handle some of these, and I'm sensitive to the time.

Each family is uniquely identified in DEERS. Each family is uniquely identified with the family identifier. Each beneficiary within that family identifier, is given a beneficiary ID. We have something we call the DEERS ID. If you use the family identifier and the beneficiary identifier, you get the DEERS ID.

And that identifies each beneficiary within the department, and it gets you to the right beneficiary record, where you can look at the information about the choices they've made, and what their assigned coverages are.

The family identifier, when coupled with the health care coverage plan code, and that's in the beneficiary record, tells you what insurance policy they've got. And that gives you kind of the system entities that are shown here.

Then we've got information about people; we have

information about patients, and linkages using patient ID, and then we have information about beneficiaries.

It all comes together in this slide which tells you how to navigate essentially through what is a fairly complex world. We navigate through it using these various sets of identifiers. The nice thing is, these identifiers are EDI identifiers.

In other words, you're not waiting for the BENE to come in and say, "Okay, what's your DEERS ID?" They never know it. It's all system to system stuff. That's how we like it, right? Because we're going to try to move toward as much automation of this entire process as we can.

In our previous system, in our old system, we struggled with this. We struggled very hard, because a person with multiple affiliations, for example, we had to make two people. What are the chances of getting the right one?

We then nested the family under the sponsor. How do you get to the family member? Last name and date of birth. Horrible.

All of these identifier systems basically enable increased automation of the entire business function. And they are available again, within DEERS as a network service.

If you come in to us, and say, "Hey, I got the

patient ID on this guy, but I'd like to know stuff about the beneficiary." That's part of our person ID services. We're going to give that back to you. Give us coverage and queries under HIPAA, we're going to return standard responses to you that contain the standard HIPAA information.

So although it's complicated, this identifier system, when built into your interaction in the MHS is going to make the world a lot easier, and that is essentially the point of this last slide, and it is my last slide, which I think I did pretty much on our agreed-upon time. So last slide.

And that uses that identifier to pull up across the MHS, unequivocally about the same person, the same beneficiary, the same family, and the same insurance policy across all these different kinds of ID systems. When it's about people, come to DEERS and we will try and sort it out, using this identifier system that I've outlined.

Now, I'm going to turn it over to Janine Groth, who is our expert, who will talk about the different business processes, that are now one level down from this, and how they work.

JANINE GROTH: The business activities that are outlined here are also in Chapter 3 of the Tricare Systems Manual.

The purpose of going through this section is to give you a broader picture than what is outlined in the manual of the organizations that are involved, the responsibility of each of those organizations, and how the interactions between them work. What identifiers we're using for those system-to-system interactions.

The three main entities that we'll focus on is DEERS, the managed care support contractor, and CHCS interactions. As Robby said, DEERS is the system that has the true enterprise view of the data.

The managed care support contractor will have a regional view based on their contract area. And the CHCS sites also have a local or regional view, based on the information that's contained in that CHCS host system. So many of the interactions with DEERS are to get that larger picture or enterprise view of the data.

The first one that we'll look at is enrollment, and the first step of the enrollment is the member fills out a universal enrollment form. That is sent to the managed care support contractor, and the managed care support contractor accesses the DOES application that Robby referred to, to enter the enrollment.

The first step there is to select the correct family.

On the enrollment form, you have the person identification information, either the SSN or the Foreign ID. It should be the information that correlates to what is on the person's military ID card. These are considered the external identifiers and what you have on either enrollment cards or on the beneficiary's Tricare card, or on the military ID card.

DEERS will then return to you, in DOES, any of the families that match that criteria. And you can select what the correct family is.

We also return the eligibility for the family, and what they're currently enrolled in. You then have the opportunity to update the mailing address, if it's incorrect, and select the correct coverage plan for the enrollment, assign the PCM, whether it's a civilian or a direct care PCM, and if applicable, enter limited information for other health insurance, as well as fee information for the initial enrollment.

There would also be the capability in DOES, if for some reason you have the detailed information for other health insurance, you would be able to enter that at that time.

Once the enrollment is committed to DEERS, we send a realtime notification down to the MCSC, and to the CHCS site that is gaining those enrollments. On the notification we send

it using the DEERS ID.

Now that ties to that specific enrollment a set of benefits. And you can use that for subsequent interactions with DEERS regarding that specific enrollee.

When the record goes down to CHCS, CHCS also performs a mini-registration. Then that's available. If the member leaves right from performing an enrollment and goes over to the military treatment facility, they're already registered.

DEERS will then, nightly, generate an enrollment card in a welcome letter. We do that nightly, in case there has been an error in the date of entry of the enrollment, and you needed to cancel the enrollment out at the MCSC level.

So we'll send those enrollment cards and then the managed care support contractor is responsible for sending the corresponding enrollment kit.

On the notification that comes down to the managed care support contractor, we also send the patient ID. The purpose for this is to be able to store that patient ID with the record.

That will allow you to put the information on the TED record, which then supports and facilitates bringing all the data from various systems, the inpatient information, the outpatient information, along with the enrollment information

for reporting purposes.

It also allows you, if you needed to do some work with a local MTF, and you're trying to match up records of patients, you would be able to do that, because CHCS also has the corresponding patient ID.

Once the enrollment is performed, there may be a change to the enrollment; either a request for disenrollment or a PCM change. It works very similarly to the original enrollment.

You go into DOES and select the correct family. DEERS will return the current enrollment. You go ahead and make the changes, and you have the opportunity to update the address, and perform either the enrollment or disenrollment.

Again, when that is committed to DEERS, then DEERS will send notification, with the disenrollment information, or PCM information, as appropriate, with the DEERS ID. And if it's a direct care PCM change, that change will be sent down to CHCS.

For disenrollments and PCM changes, DEERS will also send a letter to the beneficiary.

Our next event is a transfer. A transfer of enrollment takes place when a beneficiary moves from one contract to another. And in this process, again it's similar

to enrollment. You select the family, and DOES will return the enrollments to you.

You select the transfer of enrollment for the appropriate family members, and when DEERS sends the notifications, we will send a disenrollment notification to both the losing managed care support contractor, and the losing CHCS site, and corresponding notifications to the gaining managed care support contractor and gaining CHCS site. We will also generate the enrollment card, and appropriate letters that correspond to the transfer.

The next event is the loss of eligibility. Loss of eligibility occurs in the cases that Robby talked about, with all these changes of family affiliations, and the status of the sponsor, or characteristics of the beneficiary.

DEERS manages all of this, and as those changes take place, we redetermine the benefits and benefit sets, and corresponding assign plans, and look at whether there is an impact to an enrollment or not.

Most of the time, these changes result in a disenrollment. If there was a divorce, if there was a separation. If there was a retirement. All of these would result in a disenrollment action.

When that occurs, DEERS will send an unsolicited

notification using the DEERS ID to the managed care support contractor, and corresponding CHCS site. We'll also send a disenrollment letter, and if it is a loss of eligibility situation that falls under the HIPAA requirement for certificates of creditable coverage, we'll also send the certificate.

There are some cases where DEERS does automatic maintenance, based on sponsor status changes or family member characteristics changes, that instead of resulting in a disenrollment, actually result in a change of a beneficiary from one coverage plan to another coverage plan. If we do that, we will also send you a notification, so you can terminate the previous coverage and start the new coverage.

The next event is a reinstatement of enrollment. This occurs in a case where we get a subsequent gain from the personnel community when we had a loss. Robby spoke about with the service systems, not all of those are realtime feeds. So there's timing differences, and we get the gains coming in and the losses coming in, and we try to match all of this up.

So there's cases where we may get a subsequent gain, where we've already terminated the person. In that case, we will go back, we'll reinstate the eligibility, and if it creates a contiguous period of coverage, we'll also go back and

reinstate the enrollment.

That will come down to you, also as a notification, that looks like a disenrollment cancellation. CHCS will also receive that notification.

The next event is fee payments. Fees apply also to cat cap and deductible. So the intent is that you would inquire on the cat cap and deductible totals, DEERS will return the totals to you.

If the person is still required to pay fees, you would send the fee payments to DEERS to be reported in the central repository for fees, and then also send a cat cap and deductible update to reflect the fee amounts.

The next one is our favorite: claims. In the situation with claims, you first perform a claims inquiry to DEERS.

DEERS will return the coverage information, based on the dates of service on the claim, the PCM assignment information that also corresponds to that period, limited other health insurance information, including the carrier, the dates, policy number, that type of thing, any Medicare information, and the corresponding cat cap and deductible totals. That will be sent down with the DEERS ID.

Once you have adjudicated the claim, then you return

to DEERS the cat cap and deductible amounts, utilizing the DEERS ID that was sent on the response.

The next one is particular to the military treatment facilities for CHCS, or also the designated provider facilities. They will perform a coverage inquiry to DEERS to get the eligibility for the person, using either person identification information, or the patient ID.

In the case of using the patient ID, and why we want to use these on system-to-system interactions where possible is, those identifiers are definitive. You will not get partial match situations, or multiple responses back from them.

There are some cases, for example, the previous slide with claims, where we are still asking for you to use the person identification information, because a person could have multiple benefit streams during the span of the dates of service on a claim. You need to be able to see both of those coming back with both DEERS IDs.

The response in the CHCS situation, is very similar to what we send back on a claims response, but they don't need the cat cap and deductible information.

The next area that I want to go through is OHI, other health insurance. DEERS will be the central repository for all the other health insurance information for the MHS.

The intention is, that anyone that needs to deal with third party collections, will be both sending information to the repository, as well as being a recipient and benefit from everybody who has been collecting the data.

So some of the participants will be more passive, and sitting back and using what everyone else has collected, and that's primarily the pharmacy system. But the goal of making this work is if everyone does the work of collecting it, everyone gets the benefit of having it there.

In the managed care support contractor case, there are multiple vehicles for sending the information to DEERS. We talked, in the enrollment scenario, about being able to enter the other health insurance information in DOES. You can do that either at the time of enrollment, or you can do that subsequently, if you find other health insurance for a person.

At claims time, when you inquire to DEERS with a coverage inquiry, we will return the limited other health insurance information. That gives you enough information to deny the claim for the suspicion of other health insurance. There's probably a better way of saying that.

Subsequently, if you get the detailed information, you can then send a separate update to DEERS. Now prior to any update of other health insurance information, we do require

that you do an inquiry to get the other full health insurance information, so that you can make sure that you're not adding something that duplicates what's already in the repository. That's true for the managed care support contractors interaction, and also for CHCS's interaction.

In CHCS's case, they will be utilizing the HIPAA 270, 271, to do their eligibility inquiries. We're also able to send very limited information back on a 271. They will subsequently collect on the detailed other health information, and send that to DEERS.

Now, the good news on this is, if there had been a beneficiary who was not enrolled, who shows up at a direct care facility, part of the business process is, we will be asking for other health insurance information at that time. If they turn around, and two months later enroll, you're already the recipient of that information.

The next slide talks about the information flow for collecting primary care manager information into DEERS, so that it's available in DOES at the time that we perform enrollment and PCM changes and transfers.

So we have designed a process to collect both a civilian and direct care PCM information. And in the MCSC case, you'll still have your own provider repository, where

you're performing various provider maintenance. We just need a subset of that data for the PCMs to support the PCM assignment. That's a nightly process that you'll send us those updates.

The same thing will be happening on the direct care side. At the MTFs, they will be managing the providers, and providers coming and going in CHCS. That information, then, for PCMs will be sent to the enterprise-wide provider database on a nightly basis, and sent to DEERS.

Once we have the information in DEERS, at any point you perform an action in DOES, or the actions listed on the right side of the screen for enrollments, disenrollments, transfers, PCM changes, any bulk changes of a PCM, where you say Dr. Jones is leaving and I'm going to assign all of his enrollees to Dr. Smith, all of those will utilize taking advantage of the capacities and make sure that we don't over assign people to those PCMs. So the capacity will be enforced in DEERS.

Our next slide is the delightful view of the transition environment. Now, because we are implementing T-NEX in a phased fashion, as the contracts expire and we bring the new T-NEX contracts in, it creates a real interesting world during this transition period.

The existing or the old managed care support

contractors are still accessing the Legacy DEERS environment. They also have local stores of enrollment year, cat cap information. The enrollment year is currently not centralized in a single place. It resides out with the individual contractors.

Currently the fiscal year cat cap and deductible information is stored in what is called the CDCF file, and that's here in Aurora. And the process is going to be changing as we go to the T-NEX arena.

The goal is to try to put a process together that makes it seamless both to the existing managed care support contractors, and the new managed care support contractors.

So the existing managed care support contractors will be utilizing a buffer process that should be transparent to them, both for doing coverage inquiries, as well as getting the cat cap and deductible information.

The new T-NEX contractors don't need to really worry about that. They just need to follow what's outlined in Chapter 3 for both doing coverage inquiries for claims, as well as sending cat cap and deductible updates to DEERS. DEERS will make sure that information for the fiscal year cat cap and deductible is transparent.

During this interim phase, the new T-NEX contractors

will need to maintain a local enrollment year cat cap file, just during this transition. One of the other things that is occurring during this period is, you're going to transition all of the policies from an enrollment year to the fiscal year boundary. That is what facilitates being able to eliminate the enrollment year cap, after everyone is up on T-NEX.

So the next slide just goes through the steps that we're covering for the cat cap. There's been quite a few questions posted to the website, so I just wanted to run through this briefly.

DEERS will first perform a conversion of the existing CDCF cat cap and deductible information to have that reside in the repository in DEERS.

Secondly, we will buffer the existing CDCF transactions that the old contractors are sending to seamlessly come into DEERS.

Third, the T-NEX contractors go ahead and use the new process for sending the fiscal year point of service updates directly to DEERS.

The existing contractors and T-NEX contractors will be maintaining these enrollment year caps through this transition period, until all of the policies have been migrated from the enrollment year to the fiscal year. At that point in

time, that will no longer be needed.

It will require the T-NEX contractors to have a mechanism for communicating with the existing contractors, in the case of transfers into or out of their contract to communicate the enrollment year cap information. That currently, in some cases, is a manual or faxed process, but that needs to be worked out during the transition how that will work.

The final slide gives you where we're shooting to, after all of the contractors are up on T-NEX. In this case, the enrollment year cap file goes away. We have the enrollments being performed through DOES.

We'll be sending you the notifications of those enrollments or any enrollment changes back to be available for your correspondence or for your fee management. They'll be the batch fee interface to send fees and quarterly fee payments to DEERS. Then when you're processing the claims, you have a little bit more of one-stop shopping with getting the information from DEERS for eligibility enrollments, the cat cap information, and other health insurance information. And then you'll be sending other health insurance as you find it to DEERS.

So that gives us the final view. And now we're ready

for questions. Thank you for your patience going through all those.

MR. BRANDEWIE: Okay. So that was the simplified view, and we'll start a session at 6:00 p.m., going to midnight for the details. Just kidding.

Well, we'd like to entertain your questions. We know that there have been a lot of questions that have come in on the website, and we've assembled not only people from DMBC but people from TMA and from the regions, Dickie England, who are really knowledgeable about how this process works.

We'd love to be able to answer any and all questions you have about DEERS, and how DEERS will work with T-NEX. Is there a brave soul who would like to ask questions? I think we have about 45 minutes scheduled for questions.

FEMALE VOICE: I'll start.

MR. BRANDEWIE: Good.

FEMALE VOICE: I heard you say, in terms of communications, if you name it, we can talk to it. Is there someplace that we can go to that describes, specifically, the communications interface? Specifically today, the interface with DEERS with the 96.2, for example. Is that something we can continue to do?

MR. BRANDEWIE: In what? Janine, why don't you

answer the question. Let me elaborate on that, because I always get in trouble with my staff, because I try to be all consuming.

We do try to be agile with communications, both in terms of the communications protocols and the transfer records. We try to design and work around what the enterprise needs in order to drive itself.

Having said that, we need to impose some rigor. And rigor comes with things like HIPAA, for example, and comes with the rules and regulations that TMA operates its enterprise on.

Within those restraints, we want to be flexible. Janine, why don't you give them the specifics?

MS. GROTH: Okay. The communications expectations are outlined in Chapter One of the Tricare Systems Manual. And although Robby said that we can talk to just about everything, and we do talk to just about everything, that's across all the interfaces that DEERS supports.

The intention for the managed care support contractors is to standardize and have a consistent way of talking, versus doing a different solution for every single contract.

FEMALE VOICE: Okay. So when you say "realtime," do you really mean "realtime," meaning that we can send an inquiry

transaction and expect a response back today? It's like a subsecond response time? Is that still the expectation?

MR. BRANDEWIE: Yes, that's the expectation. Now, having said that, if we start talking EC/EDI transactions, they have some built-in delays. We have the interface engines that an EC/EDI transaction goes through.

It's not quite as fast as the custom transfer records that we're doing today. But the expectation is, yes; that at the interface point, at DEERS itself, we're looking at subsecond response now.

FEMALE VOICE: So what I'm saying is, if the requirement of these contracts is -- we're expecting online, realtime claims processing -- and of course, you have interface with DEERS, and that certainly has an impact on the kind of response time that we can give people doing claims.

MR. BRANDEWIE: Yeah. That, I think, and I would defer to TMA, but the idea of online, realtime claims seems like a very laudable goal. And I think we want to do that.

FEMALE VOICE: I just have one more. DOHI data, that is -- and I'm going to use the term "a free-for-all," meaning anybody can update it, anybody can access it. So there's no thoughts of OHI ownership by any entity?

MS. GROTH: We do track who originally entered the

OHI information. And that is visible to you on inquiry, so you can see the source. There are no business rules put in place saying that if you were the one who entered the OHI policy, that you're the only one who can then subsequently touch it.

In the business rules in appendix D, I believe, it outlines what rules we would be enforcing around the creation of policies, and I believe that there was one restriction about removal of a policy. But I don't have every single one of those memorized.

FEMALE VOICE: Okay. Thank you.

MR. BRANDEWIE: Liz, are those answer okay? Thanks. Those are great questions, by the way. Those are the kind of questions that we want to kind of tease out of you guys, 'cause we want to know what's on your mind. And we want to, while we've got the people trying, for the group as a whole, to get as much information as we can on the table.

MALE VOICE: I have a question. You state that the enrollment data gets sent to the MCSC's realtime, and we get all the changes. But then there's a requirement that during the claims adjudication we have to query DEERS to verify the information. Why can't we why use the data to get sent realtime to the claims adjudication?

MR. BRANDEWIE: Why can't you use the enrollment

notification to adjudicate the claims?

MALE VOICE: If we already have the enrollment data, because it gets sent realtime.

MS. GROTH: The expectation of what we will keep in sync with you for notifications deals specifically with what the latest, most current record is. And we send, basically, a database image of that current record.

When you go to process claims, you could process claims back three years online, and even further for certain adjudications.

DEERS is keeping track of any changes that happen from an eligibility point of view that would impact history. And we are not expecting, and it is not designed or intended, to keep you in sync on history. So what you have in your database is really only good for what the current record is, and that's why you need to come to DEERS for the claims.

MALE VOICE: Okay. Thank you.

MR. BRANDEWIE: And that's a great question and a great answer. Think about the time dimension. DEERS has to track the time dimension.

Just as a point of information, we're making about 250,000 substantive changes a day to the sponsor population. So that's a lot of dynamics going on every day that can affect

enrollments. It's always a claim for who, when. Sir?

MALE VOICE: Good afternoon. Question: how much time prior to the first required benchmark will new DEERS be available for testing?

MR. BRANDEWIE: Good question. We're going to toss that hot potato across to Peter Koste.

MR. KOSTE: It's our intention to have systems available for testing September, October time frame, with a benchmark for the first T-NEX contract occurring during the month of November, because that has to be completed by November 30th.

MALE VOICE: Would DEERS be amenable to testing with new contractors directly after award, in terms of where they are to date, to try to make sure we can deliver the best product?

MR. BRANDEWIE: You mean kind of iteratively testing? In other words, testing certain functions as they come?

You know, I guess the partial answer to that is, if it's SOUP, we can do it. You know what I mean? If we have completed -- we are doing, I think there are 24 projects that we are doing to change DEERS to get it ready for T-NEX. There is a critical mass to provide the functionality.

So one of the questions will be, have we created

enough of the functionality that's meaningful to test. And the other -- Janine, why don't you answer the second part of that question.

MS. GROTH: In our experience, there is quite a bit of work that's required just to get a test environment established on all sides and with all parties. The test environment will include interaction not just with the managed care support contractors but also with CHCS.

So some of the answer to that question is not just dependent on DEERS capability to be ready for that test period, but also the other players in the puzzle.

Secondly, we would encourage starting very early to be able to get those connections established for the environment, and make sure that the data sets are in place, to facilitate that when the testing starts, it really is ready to start, versus using up the testing period for fixing those kinds of problems.

MR. BRANDEWIE: If I were to interpret that, and I always get in trouble for this, the answer is yes. We're going to start working with you after award, to make sure you're ready to start.

As soon as it's SOUP, that you're up and ready, and ready to go, and not worried about "Gee, do I have the lines

ready? Do I know what the IP addresses are?" The kinds of housekeeping things we need to get set up.

MALE VOICE: Robby, let me press my luck a little bit further, then. Is it possible that DEERS may be amenable to working with the current contractors on some of the data elements that are there right now? We believe that the sooner some of the things you're doing can be known, in terms of what we're looking at in terms of number of data modes, that elements the size of fields, those type of things, we could try to prevent a lot of work down the line?

MR. BRANDEWIE: There's a technical answer to that, but I'm going to defer to TMA on that. Technically, I know what the answer is, but I'm going to defer to the contract --

MR. KOSTE: If I'm understanding your question, you'd like to start testing early before the -- as an existing contractor, to start testing with new DEERS. That's not part of this arrangement at all. We're not modding any of the existing contracts for you to start testing. We're not going to start developing, you know, new test environments for you to access.

We're providing the -- we're providing the file layouts at the time, following award at the technical spec. meeting. We're not giving advanced answers to what the

technical specs are. So I think we're inclined not to set up testing with the new DEERS, with existing contractors, prior to award of the contracts.

MALE VOICE: Understand, Pete, what if the existing contractors were willing to work with you even without a mod?

MR. KOSTE: I don't think so. And the reason why I say that, and of course I could be overridden, but I don't think we're going to do that because of the resources that are involved in doing that.

There's the labor and the folks and, again, the hardware and software resources, communication resources, all of the kind of coordination work that would have to occur between the existing contractor, and DEERS and us.

Frankly, we've got our plate full trying to get these 29 projects up and running before T-NEX to divert our attention to try to help test existing managed care support contractors systems with new DEERS. I don't see it in the stars.

MALE VOICE: Thank you. One question I want to get down to weeds a little bit. In OHI, I would like to get down the weeds a little bit on a couple of questions. In a lot of cases, we're going to receive OHI information based on payment information that's requested that comes in with a claim.

A lot of times, it does not contain specific

information about the OHI. I know, Janine, you talked about that in terms of going out after that information afterwards.

If we do receive information and there is information on DEERS related to OHI, could we just assume that the OHI information is matching the same contractor, even though the claim itself doesn't specify?

Or does the contractor actually have to know who did the other health insurance payment before they can make the payment to the beneficiary or provider?

MR. KOSTE: Regarding OHI, the system of record, the database of record for OHI, for claims processing purposes is not DEERS. Managed care support contractors are going to be expected to maintain their own OHI files, and process claims against the OHI information that comes in on claims.

Now, there is a requirement that the managed care support contractors update the OHI file on DEERS within two -- I believe it's two working days, two business days, upon realizing that there's been a change, or something different in that.

As was indicated before, OHI information can be loaded onto DEERS through DOES. And that could have been eight months ago. Suddenly you get a claim in, and that claim has OHI on it that doesn't match up with what was loaded eight

months ago.

So we're going to expect you to process those claims against the data on the claim, and then notify DEERS, and make the change of the OHI information on DEERS updated there.

MALE VOICE: Thanks, Pete.

MR. BRANDEWIE: Great questions, also.

JACK SIMPSON: Jack Simpson for ALPA. I just wanted to ask some clarification questions, if I could.

MR. BRANDEWIE: Sure.

JACK SIMPSON: Looking at the RFP and what I've heard about today, is it going to be a requirement that everyone that accesses DEERS will have a common access card, and that they will have an ADP background check accordingly?

MR. BRANDEWIE: That's a great question. There's a short answer and a long answer, I'm afraid.

The short answer is, that is the policy of the Department of Defense that everybody that uses and accesses a data system that has personal sensitive information in it must have an ADP designation. Okay? And that ADP designation is backed up by some form of background investigation. That is the policy.

How it will be implemented, with respect to the managed care support contractors, I would ask Pete to come in

on, or -- are you ready to do that, or -- I don't want to throw you a hot potato, but the regulation is out and published. And it is DoD policy that will happen.

Now, the entire infrastructure is not converted now. In fact, if I were to guess, I would say that 80 percent of the infrastructure is operating on the old rule set, not the new rule set. So how that transitions is really a business process question.

MR. KOSTE: If I may, could I defer and point us to the DITSCAP presentation that Dorothy Williams will be giving to us later on this afternoon? That may help answer some of the questions.

MR. BRANDEWIE: And with respect to the cap, I mean clearly the managed care support contractor agent population is eligible for a CAC. They meet the policy for issuance of a CAC. That would give them digital credentials that would secure the sessioning, for example, with those.

There again is a Department of Defense policy that all applications will be PKI enabled, I think, by the end of 2004. The CAC would be the enabling mechanism, or would be an enabling mechanism for that PKI enabler.

So clearly you meet the requirements, or the managed care support agents meet the requirement for CAC, and for those

of you who are not as familiar, that's the new smart card identification card in the Department. It could be used as a mechanism for PK enabling, essentially, those transactions that you're doing with yours.

Whether that would be the method we'd choose, again, it's a business process question.

MALE VOICE: I understand. And I'll defer to Dorothy Williams, when she gets up here with DITSCAP. I've got a couple other questions.

One indication there that DEERS ID, that the patient ID is the same as the DoD person identifier?

MR. BRANDEWIE: Yes, that is correct. The patient ID that's used in the MHS is what we call the, and I'm sorry for all these acronyms, the EDI PNID. EDI, electronic data interchange person identifier and the patient ID are the same identifier.

MALE VOICE: Is there any chance that that's going to change for any kind of --

[Recorder malfunction. Sound inaudible.]

MS. GROTH: The plan is, when and if that occurs, will obligate (inaudible) -- health care providers.

MR. BRANDEWIE: That would be an alternative, too. I mean, DEERS provides PIDS, person ID services, (inaudible) --

numbers, for example. Different numbers coming in, in various that personnel infrastructure. DEERS captures all of them and uses them (inaudible) HIPAA ID.

MALE VOICE: (Inaudible) last question. (Inaudible)

[Recorder malfunction. Inaudible.]

MS. GROTH: ...prior to the HIPAA mandated date of October 16th, 2003.

MALE VOICE: I'll wait for the CHCS presentation. Thank you very much.

MR. BRANDEWIE: Good questions. Again, these are getting hard. Yes, sir.

MALE VOICE: Mine is more a telecomm question. I'll skip references unless you'd like 'em, but at one point in time in the Tricare Systems Manual, it says that all long haul, telecommunications lines, equipment and everything will basically be maintained by the contractor. In another place, it says the contractor is responsible for dedicated primary backup for DEERS and claims processing.

The question I have is, how will the --

[Recorder malfunction. Inaudible.]

MR. KOSTE: To answer your question, the contractor will (inaudible) -- and (inaudible) established with coordination with DISA and (inaudible) FDS.

With respect to the second part of your question, it's up to the offerors recommendations in how they're going to propose to connect to those locations. I think we're leaving it in your hands, not telling you how to do it, and let you come to us with your proposals.

MALE VOICE: Okay. So the second part of the question has to do with the DCS system, and I can ask that later on, if you want, but it's a telecomm question.

It states in the document, with regards to the DCS system, that you will be able to access it via the NIPRNET. There seems to be a statement in there. Is that also pretty much open, or is that the access method, telecomm method?

MR. KOSTE: It's our intent to go through the NIPRNET. However, if you don't have a connection to the NIPRNET, we're also allowing access through the regular Internet. So as long as you have a way to either of those vehicles, you can access the DUP system.

MALE VOICE: The reason I ask the question is, because inside of the NIPRNET document is a little statement that makes a comment about a closed system. And what we're trying to understand is, that can have a very small impact or a very large impact. You can have a closed network, which is not that big of a deal, but it's problematic.

Or you can have a closed system. In the case of a closed system, that means that you can't leverage software, hardware anywhere in any of the enterprises you currently have. You basically build a brand new infrastructure to build up, and I just didn't know -- that's where the concern comes in, I guess.

MR. KOSTE: I understand. I think where you're coming from is the document that was proposed for connectivity to DISA, to the NIPRNET. That document is governed by DISA, Defense Information Systems Agency. Currently, that is the recommendation that is in the proposal.

We are currently working on an alternative method, that would make life much easier for the bidders, but we do not have final authorization on that.

So we are trying -- we recognize the potential burden of scope with that respect, but to date, the separation and the closed system interpretation stands.

MALE VOICE: Okay. Thank you.

MALE VOICE: Pete, if I could follow up on that. Thank you, Ron, for that entryway.

Actually addendum one to the TSM, Section 11, paragraph D, to be precise, is rather onerous to anyone in this business. I understand Mr. Paige's intent in the language of

the attachment, or the addendum. And I understand the message traffic from DISA D(3) and the Joint Chiefs, et cetera.

They make it very clear, very clear, that if you are going to connect to a government system, that you will have a closed network or system. And I'm not asking for clarification from DEERS or from anybody, but I just want to throw it out on the table that I think that has to be put to rest before we go home. At some point, somebody has to address that.

We have any number of questions that we are proposing to ask you, and most of them deal with that specific addenda from DISA. And I understand what Mr. Paige would like.

I just think that it's very onerous to a contractor to have a dedicated system stand alone to process government contract. Thank you.

FEMALE VOICE: There's a reference in the Systems Manual to beneficiary enrollment over the web. And I'm wondering about timing on that primarily?

It talks about COBRA ending with the managed care contractors. I'm presuming we could link to your site to facilitate that, and I'm wondering about timing.

MR. BRANDEWIE: Well, part of that, I think -- and first of all, we have been asked, and we are building a web interface for beneficiary enrollment. Having built the

interface doesn't mean that you put the business process in place.

And I think that if I could defer to Capt. Kelly's presentation, on the Tricare Online Portal, which is where we're talking about parking that capability, we can answer your question. I think it's definitely a -- it's a little out of my area, because I'm more a technocrat.

I mean, we can definitely build it. We have the business rules for DOES obviously already set up.

We're working with managed care support contractors existing to kind of, in the defense infrastructure, to get the requirements set up, and then we're going to instantiate those business rules on the web application, definitely on the road map.

Whether that means that business process should be put in place, is a separate question. What can beneficiaries do? Will they want to do it? And I think Brian Kelly addresses some of that in his Tricare Online Presentation.

FEMALE VOICE: Thank you.

MR. BRANDEWIE: Okay. We've got 40 more minutes.

How come nobody has asked, "Robby, what's the most number of children in DEERS?" Think of a number and I'll tell you the actual number. Nineteen, in one family? Oh, yeah,

that's right. That's good. In one family.

How many thought greater than twenty? Greater than thirty? It's like forty-five.

It's forty-five, and it's a little bit of a trick question, because there's an Army chaplain who adopts children, underprivileged children from around the world, and he has a huge family. It's a trick question. We know him personally. Calls in all the time. I've got another one.

Okay. He's one of the guys who broke our old system. We, of course, took a moralistic view. We said, I think it was, 19 children was that --

MS. GROTH: And we kept expanding it ten more.

MR. BRANDEWIE: Yeah. So he kept breaking our system by adopting these children.

MALE VOICE: Let me go back to the response time issue again, because it's really important.

MR. BRANDEWIE: Sure.

MALE VOICE: In an online environment, the RFP states that the socket-to-socket response time, average response time is seven seconds. The question I have is, what that would mean to me is, from the time you receive the actual query, to the time -- from the time you receive it to the time you send it back out, it sounds like it sits in your system for an average

of seven seconds. That's what I'm trying to understand, 'cause right now, it's subseconds.

MR. BRANDEWIE: Okay.

MALE VOICE: Now if it goes to seven seconds, my realtime environment all of a sudden starts to degrade and I have FTE issues.

MR. BRANDEWIE: Boy, it's really hard to be a technology guy and talk about contracts, isn't it? We do not -- and I'll speak from a technology point of view, and I can't speak to the RFP. From a technology point of view, we are building up the server set on DEERS.

The subsecond response you're getting from Legacy is coming from a main frame that, quite frankly, is fairly old. And we're building up a new DEERS, as you saw, that's more complicated. It's more complicated to get to the right place. It's a more robust relational database.

The other, especially the existing Legacy covered in the claims query system, is really kind of kluged together, but it's small and kind of special purpose.

Our intent is to translate that kind of response time over to the new system. And we are putting servers in place that will do that for us.

I'm going to hedge a little bit. Because of the

complexity and because we're going now in a different access, we're actually going through the core and the rule base, to some extent -- not the rule base, but the core to get this stuff out, there may be a slight degradation in response time.

But from a technology point of view, I would be very surprised if it's seven seconds. You know, it won't be much different, I hope, than what you're seeing now. We have some data that shows that.

We are running a bunch of applications on new DEERS. We have been tuning it to try and get response times up. And we're seeing pretty good response times, in the subsecond kind of variety.

Another class of transactions, though, are EC/EDI transactions. And there we have to send them, as you do, through some kind of interface engine. And that -- we bought software that allows us, I think, very agile EC/EDI transaction capability, but I think it's going to slow us down a little bit.

So even though the expectation when HIPAA was created was that we weren't necessarily doing realtime business, we still think we can support realtime business. It won't be as fast as some of our custom transfers are right now. Is that fair? And Pete has protected us in the contract venue.

MR. KOSTE: And Ron, could you point to where you read the seven second commitment? Do you remember?

MALE VOICE: I can get it to you later.

MR. KOSTE: Yeah, would you? I'd appreciate that. Thanks.

MALE VOICE: It's in the very back of the document.

MR. KOSTE: Yeah. I want to up it to 15 seconds.

MALE VOICE: I just saw your pharmacy systems die all over the world.

MR. BRANDEWIE: Janine, anything you want to comment on that? Our intention is to be a network asset that supports realtime operations. And we will move heaven and earth to do that.

MALE VOICE: I have it right here for you, Pete. It's in the Tricare Systems Manual, Chapter 3, Section 1.5. And the actual reference is 1.10.1 performance characteristics, page 41, if that helps.

MR. BRANDEWIE: I will tell you that in dealing with a nameless government agency, that maintains of a lot of our CALM, and has information systems in their name, we had to change a timeout parameter from three minutes to nine minutes for a certificate request, because it was taking them that long. And that was a realtime process. Realtime is relative

in the Department of Defense.

MR. REARDON: Additional questions, thoughts or comments.

MR. BRANDEWIE: Couple more.

MALE VOICE: Just one more question. That would be connectivity, dealing with -- and maybe we'll wait until Dorothy gets up here. But as far as DEERS, I would assume that any contractor existing or future would require some sort of an IATO, or ATO to connect to DEERS; is that correct? From a security standpoint, and approval to operate.

MR. BRANDEWIE: I don't think so. Now, I'm going to defer to Dorothy and the DITSCAP.

MALE VOICE: Really?

MR. BRANDEWIE: I think what you're doing is, I think we are legitimizing your -- well, DOES is a good example. You don't need a IPO to use DOES. Right? DOES is our application.

MALE VOICE: Currently.

MR. BRANDEWIE: And we've done a certification accreditation on DOES, and it sits in a controlled environment at a controlled interface point.

Sending a TCPIP transaction of some kind, or a query transaction, an ACEDI transaction to DEERS, we're controlling what's coming in and what's coming out. We testing your bone

fides, maybe, with machine certs or something like that. I'm not sure an IATO is needed on your systems. Dorothy, are you going to address that?

DOROTHY WILLIAMS: I cannot speak to the DEERS requirements.

MR. BRANDEWIE: No. I mean, from our point of view, Jack, we are controlling that transaction from start to finish. It is in our infrastructure. We're not touching your network substantively.

We're getting a transaction in, and we're pushing a transaction out. And we use authentication mechanism to insure that you're the right person that's legitimized to talk to us.

MALE VOICE: Right.

MR. BRANDEWIE: And that is in our CNA right now.

MALE VOICE: And I want to authenticate to your level of requirement. That's really my question. What is that? And if it's the CAC card, the common access card, is that the future access requirement for DEERS?

MR. BRANDEWIE: Yeah. That addresses, I think, a slightly different aspect of the DITSCAP. And that addresses the issue of the insider threat, or the authentication of the individual operator. So I can deliver data to you about an individual, for example, through DOES, and be confident that

I've delivered it to Health Net securely. Right?

MALE VOICE: Mm-hmm.

MR. BRANDEWIE: Now, what about the person sitting at the screen? What do I know about them? I don't know much about them. I'm trusting you guys to screen your operators.

With a CAC card, I at least get a digital trace on every transaction that person does, and then I use the digital credentials on the CAC card to set up a secure tunnel that I know I can trust. So the CAC enhances that process, but it doesn't require, I don't think, anything from a systems point of view, on the point of the managed care support contractor; merely on the person. Pete, do you want to comment?

MR. KOSTE: In Chapter 1, Section 3.3, under the Statement of War, it does say here, "Upon contract award, the contractor must be prepared to execute the DITSCAP process by providing the required documentation necessary to receive an approval to operate, and by making the contractors AIS networks available for testing," blah-blah-blah, blah-blah-blah.

Then it goes on to say, "These requirements must be met before fielding the system and before CON activity to any DoD AIS or network is authorized." So is that where you're -- that's where you're pointing, right?

MALE VOICE: Yeah, that's correct, because the

addendum A to that TSM basically states the same thing from the DISA side. So, I just want to make sure all the "i's" are dotted.

MR. KOSTE: I think it is required, the way it's written today.

MR. BRANDEWIE: Depends on the definition of conductivity, also. During a transaction add it isn't necessarily conductivity.

MALE VOICE: Thank you.

MR. BRANDEWIE: Yes.

MALE VOICE: Okay. I have one clarification and one question. Back to Kevin's question about the OHI, and Pete, your response about DEERS not being the OHI authoritative source, that kind of confused me.

MR. KOSTE: For claims processing purposes, okay? The OHI file that resides on DEERS is not the database of record. In other words, don't process your claims against it. You can get that information off of DEERS. You can update your own files with it.

But in terms of processing claims, you need to process the claim against the information that is supplied to you on the claim. Not six, seven, eight month old OHI data that resides on DEERS.

MALE VOICE: Well, I understand that. But your response made me think that if the claim does not represent other OHI information, can I rely on the DEERS data to say, wait a minute, this data says you do have other coverage not represented on this.

MR. KOSTE: Yeah, and I think that you certainly can use that, and ought to use that. What I'm just saying though is, if you have discrepant information between what's on the claim and what's on DEERS, go with the claim.

MALE VOICE: Right. Thanks for clarification, because I thought we were not going to be able to use it at all, and what's the value of having it.

MR. KOSTE: No. And I'm sorry if I made that impression.

MALE VOICE: We certainly applaud DoD and TMA's efforts to reduce the complexity in this data environment. You're taking on new things in DEERS that have traditionally been supported other places.

At the benchmark time we start work, if we're not there, what's your backup strategy for implementation?

MR. BRANDEWIE: You mean if we haven't implemented the -- I would say 80 percent of what you say is in what we call "new DEERS." Let me clarify that for a second. We

redesigned the system and fielded it in 1999, with about 80 percent of the concepts that you saw in that presentation.

The MHS, for a lot of reasons, has not connected to that new infrastructure yet. And so what we do is, we reverse engineer what you see in the MCSC environment, to do claims and coverage queries. So 80 percent of that is already built.

The 29 projects, now, fine tune that for T-NEX, and they fine-tune it by introducing, for example, cat cap and deductible; full visibility on that. Fee payments, the substance of what was in that presentation exist today, in his introduction today. Does that make you feel better?

MALE VOICE: Yes. Thank you.

MR. BRANDEWIE: So we're working at the margins. It's a big margin, and Tom Carrato will have words, I think, with us if we don't finish it on time, and we have committed to him to finish it on time, and we will finish it on time. Yes, sir.

MALE VOICE: I have a very brief question. Chapter 3, Section 1.4, under government furnished equipment. In that list it includes mention of a general eligibility application.

MR. BRANDEWIE: Yes.

MALE VOICE: I haven't heard that mentioned yet.

MR. BRANDEWIE: Yes. In the -- could you give that

cite, again. I'm sorry.

MALE VOICE: Yes. Chapter 3, Section 1.4.

MR. BRANDEWIE: Yeah. Talks about as GFE, a general inquiry capability. And we are -- there are, in the existing DEERS world, there's a legacy -- what we call a GIQD, general G-I-Q-D, general inquiry -- what does the D stand for? Of DEERS, oh, yeah.

We're moving that to the web. We're actually moving a family of applications to the web that allow visibility, again, on this authenticated basis, and licensed basis, allow visibility into DEERS, over the web of various pieces of information in DEERS.

Remember, I said we're trying to move to a service environment where we're providing services out? Yeah. And that's what that refers to. That is 80 percent developed already, so that one will be in production well before T-NEX.

MALE VOICE: Okay. Thank you.

MR. REARDON: (Speaking away from microphone) Additional questions? I don't know that we could have answered all of your questions related to this subject, but we answered the ones that you had on your minds today.

Let me thank Robby and the panel for doing an excellent job. And let me thank you all for asking -- first of

all, listening to the briefing and internalizing it. But then asking some good questions.

We did bring this group of experts together so that we could answer your questions when you asked them here on the floor. And I think those are great questions, and I'm pleased to see we were able to answer most of those questions.

I think there is an opportunity, John Meeker would know more about this, on how to submit additional questions, as you think about this and want to get more questions to us. There are opportunities to do that, John?

MR. MEEKER: (Speaking away from microphone) Certainly. The website that we have. Many times you'll have questions, go on our website and submit that to the contracting officer. And then we can answer the questions most of the time.

MR. REARDON: Thank you very much. What we will do now is take a 15-minute break. My watch says that'll be coming back here at 2:35, and at that time I believe Capt. Kelly will be talking about Tricare Online, and a bunch of other stuff.

[Break taken.]

MR. REARDON: Take our seats, please. It's 2:35, so it's time to kick this thing off, again. Let's come back in, now. We need to keep this rolling. We don't want to go too

late into the evening.

We're ready to begin, if everybody will please take their seats. We don't want to keep Capt. Kelly waiting. Gary Whittaker, will you please shut the doors.

Okay. We wanted to start. Mr. John Meeker has an announcement he wanted to make.

MR. MEEKER: Actually, I just wanted to make a clarification on an answer that was given. There was a question regarding whether or not we would entertain testing with incumbent contractors on systems, and the answer to that question is just plain "No," for a lot of reasons.

Pete listed a number of reasons which are valid reasons, but at this point in time, given that we're in a pre-proposal scenario, we will not entertain anything with our incumbent contractors with regard to systems development.

That's for any new offerors that may be out there, that aren't incumbents. There will be no unfair competitive advantage, and we will do everything we can to avoid that. If there are any more questions on that, please ask them. It's really a pretty simple answer.

I think that Pete just wanted to be nice and not just absolutely say "No." Any questions anybody has? All right. That was it. Thank you.

MR. REARDON: Thank you very much, John. I've been told I need to stay close to the mic so they can record everything I say. That's maybe why I was drifting away.

The next session should be a very interesting session. It will be chaired by Capt. Brian Kelly. Brian Kelly is one of the many superstars that we have in the Military Health System today.

Brian is an Intensive Care Neurologist. Brian is still practicing at the Naval Hospital, Bethesda, the National Naval Medical Center. Recently received an MBA from George Washington University.

Brian is really the father of our Tricare Online, which is our e-health portal, which will provide access to all our beneficiaries worldwide, all providers, beneficiaries and administrators the ability to perform many common business functions using the web.

Brian will tell you the fact that it's operational now, and 80 to 90 facilities worldwide, and we're looking at a full deployment this spring.

In addition to Tricare Online, Brian is also going to discuss the referral and authorization process that we will be implementing in the next year. The referral and authorization process is one which will be in compliance with HIPAA,

electronic transaction, and code sets, which is due to be operational, as you all know, about a year from today. Brian has made a lot of headway there, and I think we're ahead of the power curve on that one.

The last item that Brian will be talking to you -- I know everybody loves architecture discussions. And Brian is going to spend just a few minutes talking about the enterprise architecture for the military health system.

I think it's important -- what you're seeing here today are snapshots, small snapshots of capabilities and business processes within the enterprise.

One of the major initiatives with the current Secretary of Defense is to develop an enterprise-wide architecture for the Department of Defense that ties in not only medical, but personnel, logistics, intelligence, finance, and many other functions.

Brian is leading the charge for the medical community, and the architecture, which Brian has developed, the MHS, Military Health System Enterprise Architecture, has been acknowledged as one of the leaders in the federal government today. So Brian will spend a few minutes at the end of his presentation explaining the architecture, and explaining how you can go on the web and actually get into the architecture

and see the architecture as we have it today.

So with that, I will introduce Capt. Kelly, and I will introduce Nina Mahen, who is Brian's assistant. And we'll be using both the web and some powerpoint during the presentation.

CAPT. KELLY: Thank you, sir. Good afternoon, everyone. What I'm going to try to do in the next 35 to 40 minutes, so we'll have at least 20 minutes for questions, is give you a brief overview of these three capabilities.

What I need to sort of preface it is, you heard just a wonderful presentation from DEERS. Well, DEERS is a very well established system. It's been around, as Mr. Brandewie mentioned, for over 20 years. It's a very mature process.

What I'm going to talk about are three initiatives, all of which are less than 24 months old, from a dead start. All of which are very rapidly maturing, and all of which, I think, are going to be incredibly important as we move forward together.

And what I want to do is, I want to frame them each, starting with Tricare Online, as what it means, and then talk a little about referral and authorizations, and how we're trying to do both system development and business process re-engineering.

Then as Mr. Reardon mentioned, I really do want to spend a few minutes on our enterprise architecture, because when I first came to TMA a few years ago, I asked questions like, "Well, what's the business process for doing this?" Or, "What's the system that supports this?"

As most of you know, we have over 80 systems in the military health system. And our architecture really provides a very easy to navigate road map to tell you, this system supports this business process.

And I think for people that are not familiar with the MHS, and would like to learn more about the MHS, it's a good way to start. And it will be available on our Tricare dot OSD dot mil site, by the end of October for you all to take a look at. Next slide.

The first topic is Tricare Online. Fundamentally this is an effort that started on August 28th of 2000, so we just had our second year birthday. We made a lot of progress.

Fundamentally, it has a very simple value proposition. We are trying to develop a single, secure, Internet based platform to connect providers, patients and managers across the Military Health System.

And when we say that, in the big picture, we clearly want to include our managed care support contractors as part of

this community that delivers care.

Now what we really try to do fundamentally, with Tricare Online, and what its primary value proposition is, we want to be the secure, trusted infrastructure, that will authenticate the patient, will authenticate the provider, and will work with you to authenticate the managers. And once we've done that, then you really can e-enable processes extremely well in an effective way.

One of the major barriers to entry, for any of you going out and developing a web based application for providers, managers or beneficiaries, is the need to appropriately authenticate the beneficiary.

Because our beneficiaries also have national security implications because of their jobs, our bar for authenticating the patient may be a little bit higher than it is in the commercial sector. I assure you it is.

So what we, the government, want to do is we want to do the heavy lifting of that authentication piece, take that off your back, and provide that to you as a framework upon which you can build applications. This is the vision of Tricare Online.

So the picture here is supposed to just show that we, Tricare Online, will be the ones who will basically link

through the Internet and the DISN, us, patients, beneficiaries and managers to various legacy systems that both exist within the Military Health System, at DEERS and at the Managed Care Support and Claims Processing sites. Next slide.

Now again, our background was, when we did this secure portal, that was first and foremost. And when we looked at our MHS business plan, that I'll talk about in our architecture, we really wanted to do this to support two primary business processes: improving access to care, and then being -- enabling an e-linkage between our docs and our patients.

If you can enable that e-linkage, then it becomes very cost effective to do good disease management, to send people disease reminders, and do it in a very secure, very automated way. Next slide.

We've done a bunch of business cases on this. Not only is this a smart thing to do qualitatively, but if you've ever seen any of the cost benefit analysis of moving various processes, such as claims, appointments, referral and authorizations, enrollment, eligibilities to a self-service web model, you often can drive the cost to approximately 15 to 20 percent of the manual process.

When you think that we did over 45 million claims

last year, we did over 40 million appointments, we did 15 million referral and authorizations, you can see that those types of savings have significant economies of scale.

The other thing we wanted to do, and I'll talk more about this when we talk about architecture later, is we want to change the whole paradigm upon how we develop our systems, and how long it takes us to get a system deployed across the Military Health System.

Typically, when we've develop a system, whether it's been with DEERS, whether it's been internal to the Military Health System, whether it's been the contractors developing the system, they basically have gotten the requirement, gotten the funding, figured out what they have to do, and then they go and hire an integrator.

That integrator goes out and comes back to the functional experts and says, "Here's how I'm going to build the system. We're going to use this platform, we're going to use this operating system, we're going to use this data base, and we're going to use this software."

Then they go out, they build it. And then we go through the DITSCAP process. We go to the security process, we figure out how we're going to connect it to all of our sites. That is a very long process; that's a very costly process.

What we're trying to do with TOL, and with our whole model of pattern development now is, let's develop a platform that's secure; that has the basic functionality that now we can develop applications and link applications to, all within a common framework. We feel if we can do that, we can bring speed to market, and a lot of economies to scale for how we do everything.

We really are looking toward partnership arrangements with our managed care support contractors to enable this vision within a common framework. Next slide.

Now I'm going to tell you a little bit about the TOL site. I'm going to take you to some screen shots. We have a live demo, but because I'm trying to do three presentations in 35 minutes, and even though I'm from New York and I talk very fast, it's just faster to go through screen shots than it is.

But you're all welcome to go visit our site at www.TricareOnline.com.

Right now we have spent a lot of time dealing with security and privacy. I'll talk a little bit more as we go through the slides.

If you go to our current site right now, we give a benefits explanation that once we know who the patient is, it's really tailored to them. And I'll show you how this works.

We allow people who are either Tricare Prime or Tricare Plus, enrolled at MTFs to make appointments with their primary care manager. That will be expanded in January to include also some self appointment services. So if they want to make an optometry or podiatry appointment or a dental appointment, they might be able to do that.

We basically give people access to a lot of great health information. We did a very extensive down select of 70 leading health content vendors in the United States. We feel we picked the best of the breed product.

We present our patients 18 million pages worth of high quality health content. It is managed by an ASP provider. It is all developed by nurses, reviewed by physician panels, and is updated by our ASP provider.

We allow people an online drug, drug interaction checker, as well as the micromedics consumer dot catalog. And again, we also have a personal health journal where our patients can go in, self enter medical information. It's a secure electronic vault.

So anywhere they are in the world where they have Internet access, they can download an ER summary, so if they're traveling, have to go to the ER, they have their health record accessible to them. Next slide.

In the next 12 to 18 months, we plan on adding these capabilities. These are all currently funded capabilities. We will basically be allowing our providers and managers to securely accessed CHCS through the portal.

We will be rolling out a national and both CONUS and OCONUS capability where we will allow any of our beneficiaries, prime or not prime in any category, to basically access a web based refills at the MTFs and through the new National Mail Order Pharmacy.

We will be sending telephonic appointment reminders to all of our facilities worldwide. We will also allow beneficiaries to send an e-mail to their primary care manager requesting a new prescription.

Let's say there's a difference between a refill and a new prescription. A refill is, you have five refills and it's already at the pharmacy. After the last one has run out, I need to go back to my doc. Why can't I just send an e-mail to the doc saying "Gee, I'm out of my cholesterol medicine. Can you refill it?" And very often they can without having to see the patient. Sometimes they have to call the patient, but we'll basically support that type of capability.

Same thing with certain routine blood tests. If it's time for my annual cholesterol check, or an annual mammogram,

or something like that, why do I need to go see a doc just to get the appointment scheduled. We're going to try to facilitate that through e-mail.

We will eventually be supporting the HEAR, and then I'll talk a little bit more about our approach to security, in a minute, and we will move it down the patient provider secure e-mail route over the next 18 months. Next slide.

Now where are we? Again, we started from a dead start in August of 2000. We went into ALPA testing at four sites that are listed here in June of 2000.

We currently are deployed to 92 sites, fully deployed there. The entire national capital area, all of region nine, all of region 11 less Alaska, and central Europe.

Our goal is to be worldwide deployed by the HIPAA privacy compliance date of April 16th. We're not sure we're going to make it, but if we miss it, it won't be by very much. It'll be by a month or two, but it will be well down the pike by this time next year. Next slide.

This is just a list. I think it's to shows the number of sites that we're currently at. I don't expect anyone to read that. But we are up right now at all of these sites, and it's working. Next slide.

Now what I think is really the more interesting piece

is, we're going to be very busy over the next eight months adding the other 400 sites across the military health system to our 92 current sites. And the good news is, we've kind of figured out how to do it after having done it 92 times, and we think it's a reasonable thing.

What we'll currently also do though is, we're changing our platforms. I know there are a lot of technology folks in the world. I'm not going to do a technology speech, but what we're currently doing is our current TOL site is a custom coded site.

We're currently in the process of moving that to the Oracle Internet suite of platform. That will be hosted down at DISA, San Antonio.

We are taking great pain to develop this in a fully JAVA compliant architecture, J2-E atmosphere. And we've already developed user guides that we'll be able to share with people in the next month that say, if you want to develop an application that rides on our infrastructure, here's how to do it.

We think this is extremely important, because when we started our TOL initiative two years ago, we realized there were 300 great initiatives across the military health system, but no way to link them.

Now what we're going to do is, we're going to be able to provide this common, secure portal, and if someone develops an AP that's J2-E compliant, we can basically figure out where does that AP fit, as opposed to what level.

Should it be an enterprise AP? Should it be just -- maybe it's an AP just for endocrinologist, so we could display it through our portal only to endocrinology clinics. And I'll show you how that works. And we think this really is going to help us revolutionize how we can develop and migrate APs. Next slide.

I'm going to just go through a couple of screen shots real fast. I know we've got a lot to cover.

This is a site that when you first hit our site, this will be the first screen that pops in your face. We have spent hundreds of hours with lawyers figuring out what are the business rules.

You can read our nine-page disclosure, or just hit, "I agree," and move forward, whichever is best. You got to do it. Okay? This is what the site looks like once you hit "I agree."

What we tried to do when we developed our portal -- right now, our portal has two views. The primary patient view, and the secondary provider view. We will have a manager view

in the next twelve months that'll be extremely important.

When we developed this, we actually brought patients in and said, "What do you want on a portal?" And it was very clear. They want security and privacy. That's sort of a given.

But they told us they really wanted two things: they wanted drugs and appointments. So we've highlighted hot links to the things that they really wanted, and we tried to arrange it that way.

They wanted high quality health information. They wanted all of that. They wanted a personal health journal. But they really wanted drugs and appointments. Next slide.

So to do drugs, what we do is you can hit pharmacy here. And we basically give information about your pharmacy benefit. You can look up a drug.

You can check drugs for drug interactions. This is what the drug interaction looks like. You actually enter any of the drugs that you are on, and it goes out, and it is drug/drug, drug and food, and drug interactions. Very nice tool. And I think it's a very good patient safety enhancement.

Even though PDTS does this, it's really nice that the patients can check on their own. I think it's a good way of teaching patients to take responsibility for their care. Next

slide.

This is just some of the high quality health content information. I would really encourage you to go take a look, and pick a disease that you know someone with, and I think you will be really very pleased.

The information is all designed at the 10th grade reading level. About ten percent of it is in Spanish. It's very good material. Next slide.

There's a thing called "Condition Explorer," which basically you point to a body part -- next slide -- and it'll give you a list of various things that might be associated with that body part, like you could access flu information, if you had a cold, or something like that, or basic allergy information.

You can e-mail this information. You can print this out. This is very useful information. Next slide.

The real benefit, and this is where I think the portal is of much more interest to the people at the conference today, is up until now, this is just a general information kiosk Internet site.

What happens now, though, when we register beneficiaries is when it really gets interesting. We basically ask people for some basic demographic information. And what we

then do is, we take this information and we go against DEERS.

If a person exists in DEERS with my name, social security number, and date of birth, I then will allow them to set up a password protected account. Next slide.

Now, when they access care, when they then log in with that password protected account, we will take them to the facility that they told us when they registered they're associated with. So this person said, "I live in Region Nine, and I go to Balboa."

We've thought about who is it that really takes care of a beneficiary in a Military Health System? It's really very simple. Tricare, the region they live in, the MTF or MTFs they go to, the clinics they visit, and the doctors they go see, or providers they go see.

Each one of these develops a web page, which takes about an hour to do. It needs to be updated every couple of days. And I now can go to any of these 92 facilities right now and look at all of the clinics, get information on the clinics, get information on all of the providers, and do things like that.

So this is basic information on Balboa. Next slide. Here's a list of all the providers associates with Balboa, and I could click on any of these, see their home page, or add them

to my personal list over here. Let's say that's my primary care manager. Next slide.

This is my page. I still practice as a neurologist out of Bethesda. And this is basically what a typical doctor page would look like. It tells a little bit about my practice, my background. Next slide.

I also can put all sorts of information for my beneficiaries and my patients that is specific to a neurologist. So I can tell people, "Here's all sorts of great resources for Alzheimer's, for MS, headaches, stuff that I take care of on a day-to-day basis." Next slide.

Now, the other thing people want is a primary care appointing. They can just hit appointments and they'll get this screen. We first give them the HICL number, or the nurse advice line number, and encourage them to use that.

We then give them all sorts of links to guides for self help, because when was the last time my wife could find that book we sent them on Help Yourself? It was sent to us five years ago. I have no idea where it is.

But this time, every time they go to an appointment, I now have current information on any of a number of conditions, and some of it is in Spanish. Next slide.

They then can basically say -- they then can pull up

real time, any available appointment with their primary care manager, or primary care manager team, and make that appointment. Next slide.

Now, what I'm going to do is I'm now going to just sort of switch gears and just talk about -- okay, that's the framework we're trying to develop. And I would ask you, from a Tricare Online perspective to think -- just think of the value of us authenticating beneficiaries.

What we're doing right now is, we're doing just a check of basic demographic information against DEERS. The thing that will start in the spring, after we finished our worldwide rollout, is each of our sites will tell the patient one time, they're going to have to go to an MTF, or some other trusted agent -- and we're still working out some of the business rules for here -- show a trusted agent at that MTF their ID card, and then we're absolutely sure that person with that user ID and password is who they say they are.

Now, we're not PKI enabled in the sense that we don't have clients at PKI. We do have PKI certs, obviously, on all of our servers.

But what we now have done is, we now have put a common framework across the military health system, that we have now authenticated all of our patient users as we move down

the road.

What will happen is, right now when you go to TOL, you can basically have access to the APs we currently have available. If you want to do things like e-mail to your doctor, or online enrollment, or online referral and authorization, check on a status of referral, we need to be absolutely you're who you say you are. We can't do that without a face-to-face authentication.

So what we'll try to do is, we'll try to do that heavy lifting, and do that authentication piece. Any communication with our portal is always through secure socket layer, and again, we're at DISA, in a DMZ, between significant firewalls, and we'll provide that infrastructure.

We obviously also have to connect to our CHCS host at all of our MTFs, as well as DEERS. All of that will be done by tempo managed BPNs. So we have now a secure infrastructure where when you come into our portal, we can access you to all of our major legacy systems in DEERS, through a secure framework.

Think of the value, and as we go forward. That's the framework we want to do, and that's sort of the vision of TOL.

Now I want to talk about referral and authorizations, because this is obviously something that is a challenge for us,

and is something that is mandated under HIPAA. Under the current HIPAA law, unless there's a change, which I don't think there will be, by the 16th of October, if we do any electronic referral and authorizations between the direct care site and the purchase care site, that has got to use the X12-278 format. End of story. That is the law.

Now what we've done, when we started to look at this over a year ago, we realized that each one of our different regions has different business rules for referrals and authorizations. But it doesn't stop there.

Each one of our MTFs have different business rules for referral and authorizations. But it's even worse than that.

Each of the MTFs within the various clinics have different business rules. And if the Comfort from Bethesda deploys tomorrow, the business rules to where that referral goes, change dynamically overnight.

So we basically said, "Gee, this is going to be a real challenge to automate." And what we've tried to do is we said, "Well, look, let's look at how we can do this and how we can leverage things like TOL to basically do this type of thing."

So we've looked at this as both a challenge and an opportunity to standardize and automate business processes.

One of the other things that we realized was that a non-availability statement, which you all are very familiar with, is just another type of referral. It's a specialized type of referral, but it's a referral.

And we looked at a 278, and it can support, easily, a non-availability statement. Next slide.

Now, what we've done is, at a very high level -- and this probably won't show very well, so I'm going to just talk to the slide briefly, but then I'll take you through some screen shots -- but fundamentally what we've tried to do is, we got a work group together, and we are working very hard to develop standardization of business rules for referral and authorizations. And this is going to be absolutely critical to the success of any enterprise wide approach to referral and authorizations.

And I'm not here to tell you that today we have all of these answers in stone. But I am here to tell you that over the next few months, as we go into prototyping, we are going to have to formalize exactly what is the amount of time allowed between when I write up the referral for a neurosurgeon from my neurology clinic, to when that referral has to actually be acted on, and the person has to then go forward to appointing.

We realize there's lots of complexity here, but we are trying very hard to develop the business rules on how to do this. Next slide.

Now, we have found that as we do requirements, it has been incredibly beneficial to -- not to actually develop mock models of how the work process would go, as our functional team is right there. And what basically this does is, this is sort of our portal on how we're going to approach this. Next slide.

One of the things we'll do is, if you're a doctor, you're going to have to be able to generate a referral. And right now I'm talking on the direct care side, but we'll talk a little bit more how this will interface with the purchase/care site under T-NEX.

Right now this system is designed primarily for the direct care site use, but you're going to see how it works and how it relates to you, as we move forward.

Under the current HIPAA change order, we really had a very simple requirement of the managed care support contractors when it comes to referral and authorizations. It's very simple.

You need to be able to accept a 278 from us, and under T-NEX you're going to need to be able to send us a 278. That's really the fundamental requirement.

Now, what our system does is our system generates a 278. And basically this is what we would first do is, we'd obviously identify the patient. This would involve an interaction with DEERS, and we've already talked to the DEERS folks, and we'll be getting into more discussion about how this is done.

So I pick John Smith, and I'm going to set up an appointment that is a routine consult, then I'm going to pick what type of care it goes to, whether it's through a nurse, or whether it's an admission, a specialty referral.

Then I need to put in various optional information and some history, just like I currently do now, and this all has to be within this 278 framework. So right now I do that -- next slide -- and then what'll happen is this is what comes back to me to review, and this is basically saying that, "Okay, I sent up this referral. I'm sending this person just to a counselor, it's a referral, and I don't have any specific requests for facilities, or anything like that."

The patient will never see this, but this is actually what the 278 message would like that we're generating, and what we will actually then send to the system.

Now the thing that will be the next step, and what we're currently developing right now is, that 278 now is going

to be sent to and applied against a table driven set of business rules that are dynamic and configurable at each MTF.

So someone at each MTF will have to go in, and they'll basically have to say, for every one of our beneficiary categories, for admissions, for referrals, for various types of other health benefits, who is the decision making authority and where does that referral go?

Now what we've found is, many of these things are kind of no-brainers. If I don't have orthopedics in my hospital, well, guess what? Any PCM generated consult is going to be going out to the network.

So we can automate that, and when that service number comes in as an orthopedic consult, the 278 is applied against the set of business rules.

This is basically a little tool we use that basically applies to all the business rules, and it says, "Okay, for this care, this one has an MTF default care, but it could go to that various activity for scheduling." We feel we can automate a lot of this process.

We realize though that there are not -- we can't automate all of these; that a lot of them do require human intervention, and someone has to look at the referral and says, "Does this meet medical necessity?"

When that happens, we'll send it to a Q where someone can then open that up and act on it. Approve it, autodeny it, request more information. And we can time-stamp this and keep things working.

If this was a referral that was going directly to a contractor, it would have automatically been sent as a 278 to the catcher's mitt on the contractor's side.

Under T-NEX, when we get to right of first refusal, which is one of the T-NEX contractors, we will expect you to send us a 278. We will take that 278, apply it against the same business rules, and then dispose of it as if it had been generated on the direct care side.

One of the other things that we think is really exciting about this type of application, if we can do this on a central enterprise level, then what we can do is, let's say I'm dealing with this Trace No. 5 here. What I can do is, when we generate this, it's generated also with a unique referral authorization key.

If we take this key, we are going to be providing a web portal for our contractors where they can just go to our web portal, enter this referral key, and then append any information back for results, back from the purchase care sites.

So if I send someone out to the network for an orthopedic evaluation, you could then append that information, scan that information, put that information in its attachment, then put it back here, hit save, and then it goes back into our system. If I'm the doc, I now see that there have been two entries of information on that referral I sent out, and I can access that information.

So what we effectively do is, we provide a framework for allowing results retrievable, linking the direct care site and the purchase care site. We think this is going to be extremely important as we move down the road in beginning to link these types of services. That's just what it would look like.

Now, the next steps, we're just now beginning to get into the system development of this. We hope to prototype it in December, November, at a couple of clinics in the national capital area.

Typically, if you look at the traditional MHS deployment paradigm, we would never have a chance of going worldwide in literally a year and two weeks from today.

What we will do, though, is we're developing this as a web service cell, that now can write on the TOL infrastructure. The TOL infrastructure will be worldwide by

next summer, so we will have a mechanism by basically embedding this and getting this out. And we've got to be worldwide by 16 October, to be compliant with the HIPAA compliance date.

Now, I'd like to spend the last five or ten minutes, and I think I'm doing okay for time, on our enterprise architecture. Fundamentally, over the last two years, we have spent a lot of time and effort developing an enterprise architecture that documents our key business processes and also relates them to the technical standards, as well as the systems that support those various business processes.

This would not have been enabled or possible five years ago, because it was really based on a lot of work that was done by our optimization team back in '99 and 2000 that said these are the four functions that we need to do very well to become a world class health organization.

So we took their model, and we basically developed it and put it on a relational database that I'm going to demo for you, that shows you these relationships. And again, this will be available on the web by the end of this month.

We're also committed, and I'm going to talk a little bit about our common computing infrastructure, about developing, moving to a very small number of common architecture patterns. And I'll talk more about this at

the very end.

We're also doing a lot of work with data standards, and learning how to manage web services and common standards for new application development.

So what we're going to do now is, this is what you'll be able to access on the web in a few months. Nina, if you could just take us down to the actual demo itself.

Unfortunately, and I'm not going to bore you with the details, but DoD has a very prescribed framework for developing an enterprise architecture. And you don't need to know any of the details.

We're going to go down to what's called an OD5, which is fundamentally what an operational -- what's called one of the high level activity models.

Back in '99 and 2000, we had a lot of subject matter experts from across the military health system work for over two years to try to define what are the key business processes that we need to optimize.

And fundamentally, and a lot of you have heard this before, we've got to do four things very, very well. We've got to improve access to care, deliver great care, do population health, which we call force readiness protection, and we have to manage our business.

Each one of these has subactivities. So you can drill down to on access to care, and you'll basically see that access to care has seven subfunctions. And if you were to go down, Schedule Services and check-in, that also has functions, and maybe just go to that one there.

It turns out that when you got through our whole business process, there are 97 core business processes, such as retrieve and verify beneficiary information that are the things we need to do very well.

I hope you'll see why I'm wasting a few of your minutes telling you about this, because I think, as you begin to learn how to navigate this system better, and as our architecture matures even more, this is a common chassis upon which we are going to be hanging all of our data requirements, all of our technical requirements, and all of our system interface requirements in the future.

So if you want to know what's the API for linking to DEERS, to do this process, our hope is, in the next two or three years, you could come here and figure that out, as opposed to having to go through many manuals, and this, we think, is extremely important for system development.

What you see here, you see all of the various major nodes or entities that have a piece of retrieve and verify

beneficiary information. Anything in blue is within the MHS. Anything in brown, is extra. And we consider the beneficiary our customer, so they are external.

Now what happens is, to do this process, we send information between these different nodes. And each of these pieces of information is called an information exchange requirement.

If you were to click on one of them, and just pick one, Nina, and click on it, what you would basically see is that information exchange requirement, customer demographic information, not only supports that business process, but it also supports all of these other business processes.

We picked that one, because it turns out that over 97 key processes, over 70 of them require customer demographic data. So guess where we're going to focus our initial efforts on standardization. Go back, if you would, Nina, please.

Now, the other thing, and probably the greatest value right now, of all of this if you go down, is that you now can click on the system interface requirements. When I first came to TMA, I would ask questions like "What system supports this process?"

And I really had to go find the subject matter experts, and kind of ask enough of them, until two or three of

them told me the same answer, and I felt, "Okay, that actually is how it works."

Now I can tell you, for this activity to even verify information, that's supported by CHCS, DEERS and will be supported by these future systems. So it begins to give us a way of linking our things.

What we're now doing is, we're now beginning to develop what are the system interface requirements, and the system APIs. And as we get into web services, and common services and common data standards, those will help.

If you could go back a couple of times and just open up the OV3, I'll show people that real quickly. One of the other views we have is called our information exchange requirements, and what you basically will see here is that for every one of these activities, and every one of those information exchange requirements, we can tell you, what's the information, how frequently is it updated, and do standard supply.

And this will be where, we hope in a few years, you'll be able to come and say, "Here's the API," or "Gee, they're using HIPAA X12 for eligibility enrollment. What a surprise."

So we'll go back to the slides. I have two more

slides, and then I'll take questions.

That's sort of on the high level architecture stuff. What we're trying to do right now on a development side -- and I think this is important for our contractors to know -- right now, as I said, we have basically 80 main central systems that we manage. Every single one of them is on its own operating system, on its own infrastructure, on it's own database.

What we've decided is that it doesn't make sense to manage our business that way. We've had discussions with DISA, and Big Air Force, and a lot of commercial best practices, and if you've ever heard Gardner talk about enterprise architecture, they'll talk about these things as patterns or bricks. We are basically trying to make a big move toward patterns and bricks.

What do we mean by that? What we realized is, that if you look at our 80 systems, they all break down to four or five basic patterns.

You need a basic pattern that does web services, you need a basic pattern that does client server type of applications, you need a type of pattern that does database and data warehousing.

And then we feel we need a pattern that's based at our CHCS host sites, at our big MTFs, because there are some

comm issues and some local cashing issues that are just realities for us.

And then we also realize that we need a common ports and protocol and firewall issues so that we can always get a -- if I build an application or you build an application that has to access one of our CHCS host sites, that you can easily get to it, and not have to deal with Army, Navy and Air Force firewall policies, and difference in policies across the MHS. So we look at those as our five patterns.

We right now are working very hard to focus on quality data developing five basic patterns that will be how we build systems. So in the future, we won't give a new program office, and say, "Here, go build this functionality." We'll say, "Here's the infrastructure, pick one of our five patterns, and we'll try to have these patterns managed by our Tri-service infrastructure management program office, so that our program developers and our services then develop APs.

We hope over time, you'll be able to see what our patterns are, and will become to have commonality. This is very consistent with the approach that DEERS is taking. Our webservice infrastructure is extremely analogous to theirs, and we think this really is the way to go.

So our goal will be to provide to all of our

customers a standard interface, a standard API. We will take care of the common infrastructure, and then those APs can be developed on top of that.

So that basically sort of concludes my presentation. I know it's been several topics, and I may not have answered a lot of specifics, but it's more of a this is where we feel we are going, and I hope it was somewhat helpful.

I'll be very happy to take questions that might be germane.

MR. REARDON: We have ten or fifteen minutes for questions.

CAPT. KELLY: I know there was a question from the earlier session that I need to address, from Miss Hudson, that had to do with web based enrollment.

One of the requirements in the new -- or one of the statements in T-NEX is that by T-NEX the government will be providing a web based enrollment application, essentially, is how I understand it.

Right now, what I can tell you for certainty at this point, though I think over the next six to twelve months we'll clearly have a better timeline, is when will that application be ready? Will it be at the very beginning of the first contract? Will it be by the time all of the contracts are

enabled, or will it be something in the middle? I don't think I have that answer for you right now.

Now the extent of that application, as far as what fundamentally it does, I think that is clearly well articulated in the RFP. But I think one of the big issues is how we move forward with developing that as a web service, so that if there are additional things that the contractors want to do with that enrollment application, how can they leverage this enrollment application almost as a common service?

I know that over the next few months, as we mature our requirement for that web based enrollment process, we will try to be articulating that much more clearly, so that people will understand where we are in that application development. That's the best I can do today.

I knew Jack would have a question, or two.

MALE VOICE: I just want to say, before I go on, what they paid me to do here today, was ask hard questions. As a beneficiary, I want to thank the senior executives in this room, and all the managed care support contractors and everybody else who makes Tricare work. It's the best program in the world.

Okay. With that said, Capt. Kelly, respectfully, and it's hard to follow behind you, Brian; trust me.

I wanted to ask a couple questions about the 278. In the RFP, it's pretty straightforward for the active duty member and the active duty family member.

There's a requirement to have a -- I would call it a second system for retirees and their dependents. And what I'm wondering is, where is the access point for referral on OTS, because I haven't seen that in the RFP? Maybe somebody can correct me here. I haven't seen where that is, the gateway.

CAPT. KELLY: I'll be honest. I won't be -- I personally can't answer that question. Pete, you want to help me out here? Please. Pete, why don't you come up here? He always gets the hard questions no one else can answer.

MALE VOICE: Bring on Pete.

MR. REARDON: (Speaking away from microphone) That's an oversight on my part. I meant to have you up here, again, and I apologize.

MR. KOSTE: The use of the 278, okay? Well, let's back up here. If you're talking about a referral, an authorization process between the managed care support contractors and their providers in the network, or non-network providers, we're not telling you how to do that. That is your design.

Now, from the point of the managed care support

contractors shop, an interfacing like for first right of refusal, or to -- what else would they do? To actually make a referral back, you have to be able to create that 278, and then send it through the referral authorization system.

On the flyback, what you're going to end up with is getting a 278 back to you, you have to load that to your own referral and authorization system, so your processing system can access it, and then you can process claims against it. And that's essentially what's going to be happening with any asset.

MALE VOICE: Right. And I guess in honoring objective one, which is MTF optimization, I wanted to be able to route the 278 to the right place.

CAPT. KELLY: The right place will be our catcher system. Basically think of the referral and authorization system as a big mitt. And all you've got to do is throw the 278 and let us catch it, and then our system will route it to the appropriate review authority and to the maximum extent possible, automate that process, and then send it back to whatever IP address it needs to go back to.

MALE VOICE: Okay. Great. Second and final question, maybe, is based on security. I fully appreciate the heavy burden and heavy lifting on authenticating everyone. I think that will be a fairly straightforward matter for the

active duty forces and their dependents that are best served by their bases or posts or stations. What about those retirees?

CAPT. KELLY: I think this is still an unanswered question across DoD. And I think we're going to all be clarifying this. This isn't just a TOL issue. This is also an issue for all of the big service portals, as well as all of the DEERS portals.

Now, I think what we're going to be requiring clarification on is, obviously for anyone to go in and hit an information system, and be able to access personally identifiable health information on anyone other than themself, you can understand why they might need to do a background check.

All we're ever going to allow from a beneficiary perspective is people to access personal identifiable health information on themselves. So it is hoped that will not be held to the same bar as it would be. So yeah, 'cause the question is, do you need to do an ABP background check on every one of our beneficiaries.

MALE VOICE: Right.

CAPT. KELLY: Well, that grinds e-health to a halt, as well as any e-gov initiative. So I think that is -- I'm hoping that some sense of reasonableness will prevail in this

discussion as we clarify these things, as we go down the road.

MALE VOICE: Okay. Thanks. I do have one more question. Deals with a statement in the RFP that talks about redundancy of contractor capability competing with -- or maybe not competing, but basically replicating government capability. And I'm just wondering, where do we draw the line, as far as things like enrollment, et cetera?

CAPT. KELLY: I think we'll figure that out over the next 18 months, really. And I think what we're trying very hard to do, with all of the initiatives that I think are part of new DEERS, is where is the natural break of what is best to be centralized and what is best to be optimized by our contractor support partners?

When I look at the whole issue of things like enrollment, I say there are a couple of things that are important to me, to the government. One is that our beneficiaries always come to a single portal, and authenticated to a single portal, so no matter where they are in the world, they come to TOL, they put in their user ID and password, and then that's how they authenticate an enrollment AP.

That AP also should look the same, at least on the front end. Who cares what the back end is doing. But it should look the same, and be fairly navigatable, or at least

the common, basic functions.

Now it may turn out that HealthMed and Hu-Man and other contractors have various additional features that they may want to present to their beneficiaries. I think we can accommodate that.

And I think right now, these are all of the discussions we have to kind of figure out over the next six to twelve months, as we move forward to developing the enrollment application. So I think we are going to have to work with you all to develop what should be inherently successful management by us and DEERS, and what really should be definite and optimized.

[Recording level malfunction. No sound.]

MR. KOSTE: ...there are some clear requirements about that.

MALE VOICE: No, I understand. Thank you, sir.

MR. REARDON: Other questions? Okay. Let me thank Capt. Brian Kelly. Thank you, Brian.

I don't want to miss the portion of the presentation on architecture and how important that is. I think that TOL, Tricare Online and other applications, are the glitzy part of the business. But what's really going to move us forward is a strong corporate architecture, and Brian is leading the way on

that. And I strongly appreciate his ability to move that forward rapidly for us.

I think what I'd like to do is take a ten-minute break, so we can get the hookup set for the CHCS-II demo. So why don't we plan to be back here at 3:40.

[Break taken.]

MR. REARDON: Okay. Could we start taking our seats again so we can get this rolling, get going.

As we begin the next part of our program this afternoon, before we move into CHCS, and I'll introduce the representatives who will be briefing that, Dr. Kelly would like to issue a second opinion on something he said. With that, we'll bring Brian back up -- or, no, you're going to do it from your seat.

CAPT. KELLY: Just very briefly, in response to Mr. Simpson's question about what the government will provide and what contractors could develop. Under T-NEX in the RFP, it basically says that DEERS will provide a web application for beneficiaries to perform enrollment related to activities.

These include an enrollment, a PCM change, address update, transfer of enrollment, disenrollment, limited cancellation events, or a request for a new enrollment card. And that's really what we're asking you not to develop under

T-NEX. Those will be GFE, government furnished. And for a reference that's on Section 1.2.3 of Chapter 3. I just wanted to provide that update for the record. Thanks.

MR. REARDON: Thank you very much, Capt. Kelly. I appreciate that.

The next hour we're going to spend on a demonstration of the Composite Health Care System II, which is our second iteration. Lt. Col. Tony Smith, when he briefs you on CHCS-I which will come after CHCS-II, will tell you that CHCS-I is installed in all our facilities worldwide, to include our hospital ships, and many of our deployed facilities.

CHCS-II is moving DoD toward an electronic patient's record, that will be available 24 hours a day, seven days a week, anywhere in the world. And Lt. Col. Bart Harmon will demonstrate that for us today.

Let me tell you, Bart is a pathologist, still practicing at Walter Reed, and he has an MPH from Harvard and he did a fellowship in medical infomatics. He is the manager of clinical requirements and clinical design for the CHCS-II system.

With him is Mr. Rich Lowell, who is the Director of Systems Integration for INTEGIC and works very closely with Dr. Harmon on many of the issues we have related to the integration

of commercial products, as we tie those together, to deliver an electronic patient record.

And we all know the gentleman at the end of the table. And he's actually endowed now. He has a seat, a permanent seat at the table. He has tenure. So we'll acknowledge him on every panel.

So with that, I'd like to welcome Dr. Harmon.

LTC. HARMON: Thank you, Mr. Reardon. It's a real pleasure to show you CHCS-II today.

I'd like to point out, as I start, that when we talk about CHCS-II being the DoD computer based patient record, there are a couple of principles I'd like to mention up front that you'll see, again, as we go through the demo.

One is, it's not just getting health information into a computer, but it's getting health information into a computer so that the computer can assist us in health care delivery. So in many systems you'll see text data that some human has to read to interpret, to make decisions, and alert rules, for example.

In CHCS-II a lot of the data is collected in such a way that the computer can be watching for events that need extra reminders, alerts, those kinds of things. We refer to it as structured data collection. With that, let's just go on

into the next slide.

Just to frame CHCS-II a little bit, we need -- we mentioned earlier that CHCS-I is present in a hundred-plus sites, so we have health data scattered around the planet. What we need is a complete computer based patient record, so that when we open a patient's electronic health record, we've got everything from everywhere in the world, no matter where it was collected, in any other place in the world that might need that health information.

That will be collected into the clinical data repository within CHCS-II. Now we will do that for our active duty service members and their dependents through their entire life cycle within the military and as they exit the military.

We bring people into the service, we train them, sometimes we send them into unpleasant situations. Hopefully we bring them back, redeploying them, but sometimes they come back on a stretcher in a plane, and frequently we transition them to care in a VA at the end of their time on active duty. We want a complete electronic health record for that cycle of care within the DoD, and an effective handoff to the VA at the end.

Now, we do have a theater product, which is actually what we're showing you today. It's the same software but

switches are set so that it can run stand alone on a laptop, because communications are a lot less reliable in a theater of combat than they are in a sustaining base where we work in brick hospitals, for example. Next slide.

CHCS-II is also laid out in increments or releases, so that we will build the function gradually between now and 2009, and potentially beyond that.

The first release, which we'll show you today. It's live running software, it's in test sites, it's through what we call the operational test, which means shortly we'll face a deployment decision to take it worldwide, supports this work flow. It's the ambulatory patient work flow.

Patients checking into clinics, getting vital signs checked, screening and wellness being done, which for us includes doing pre-deployment surveys and post deployment surveys on our troops as they're going into combat or coming out of combat. Also things like immunizations, which we do for military reasons, and for non-military reasons.

It includes capturing the clinical encounter when our provider and health teams are seeing patients, and of course, educating them, and checking them out of our clinics. This is release one. It's the frame, the work flow frame for release one. Next slide.

At this point, I'd like to stop talking just about CHCS-II and show you CHCS-II live, because I think that makes everything that much more real. We're flipping to a machine loaded with the theater version.

There's only one place where there's any difference at all between a theater version and what you see in a fixed facility hospital. There are two data elements that are collected in a theater that we don't collect from a sustaining base setting.

What you see right away at CHCS-II is a graphical system, graphical user interface familiar to Window users. To the right you see buttons. These action buttons will change from one screen to the next, because different actions are relevant.

On the left you see a folder list. This is the way of getting around the system. As we open the system up, you see the user desktop is open, and the functions that do not relate to a particular patient are available on the desktop when you open the application.

In this case Tracy, whom I should introduce down here driving the application for us today, has clicked on the appointment list, and here we see the appointment list in our clinic today.

As Tracy clicks on the patient's name, you see a second folder open. This is the patients online electronic health record that accumulates over time. It will become their lifelong, electronic health record.

Also you saw the patient's identification appear on this bar. The patient's ID will be present on every screen so that it's very clear whose record we are in.

Off to the right, you also saw some icons appear. I apologize, I can only point to one screen at a time. Over here, the nose means that the patient has allergies documented in the system. So it's just a constant alert that there's something unusual about this patient that people need to be aware of.

The parachute means that the person is on jump status. A person who jumps out of perfectly good airplanes for a living, which -- well, I'll leave that where it is.

But again, the rules for people who jump out of airplanes, for people that fly airplanes, are different than the rules for people who don't do that. If we send a pilot out on any kind of sedating medication, they can't go back to work. So these alerts are so that we know that people are unusual. We also have people that launch nuclear weapons, and you can imagine that rules for those folks are very strict.

With that much introduction, what I'd like to do is pretend that we're following a patient through one of our clinics, looking over the shoulder of the folks that would use CHCS-II to take care of that patient.

The front desk clerk, once they've clicked on the patient, because they have an appointment in the clinic, would click on the demographics folder. This is where they assure that they've actually got the right person in the clinic today.

They can also note -- this is pulled indirectly from DEERS; DEERS is the repository for all of this -- their enrollment and eligibility information, so the front desk clerk knows the benefit profile.

The front desk clerk also knows who the primary care manager is, so they know if it's someone in their clinic or not, in case the business rules in the clinic are different. The front desk clerk is done with this screen pretty quickly. So they would close out.

The next part of the work flow, typically, is that a nurse technician corpsman would escort the patient back to an exam room and get the clinical part of the encounter started. And you'll see a lot of work flow here. This is what we didn't find in many products.

They would double click on that, and what they're

really opening now, is an on-screen version of a progress note. Most people picture this as a paper page in a chart where a progress note is handwritten.

Because we have a patient's problem list, medication list, their allergies, recent lab results, those types of things electronically, each clinic and provider can decide what they want automatically written at the top of every note. You can see here that we've just chosen to put the patient's problem list and their allergies into our notes, because they're available electronically.

Our next common step -- again, these buttons on the left are -- they label typical parts of an encounter, but they're also action buttons that take you into those actions. As a patient is being processed in, we would, of course, want to ask them why they're there today. It has a lot to do with what we do in the clinic.

Because the patient, again, has an electronic problem list, they may be here for their high blood pressure, which we already know they have, it's already documented. Why not use that problem list to document why they're here today, which should show up here if we double clicked on it.

Clinics also see repeatable types of conditions. For example, common colds, high blood pressure, diabetes. So our

clinic has built this list, and we'll just click on common cold as the reason the person is here today. It becomes the selected reason for visit.

Notice that it's also coded. Most of our clinical users don't even notice the number, but because it's coded, we can trigger actions later in the work flow based on that coded data element. I think actually an ICD coded chief complaint is also useful for reimbursement purposes here in the near future. We can also search, of course, for reasons for visit.

What we'll do now is use the next button. Notice the button with the two arrows to the right, with vitals under it. Wherever there's a common next function in the system, we put that "Next" button there, and put the label underneath it to tell the user what that is. That's so users don't get disoriented, and can't tell where to go next.

Here we'll put in a simple blood pressure. Tracy will do that. While she's doing that, I'll just point out that we can also pop up additional data elements like visual acuity, oxygen saturation, peak flow here.

If this patient were a female, the system would enable us to put in some commonly collected female data that's done during encounters. Tracy has put those in.

Notice that we cross calculate between English and

metric units. You can enter in either system, depending on the device you have, to measure height and weight, and the system will cross calculate.

It also calculates body mass index and body surface area automatically. There have been cases where people would pull a calculator out of their pocket at 3:00 in the morning, and calculate a body surface area to do a chemotherapy dose calculation, or something, or a dose calculation in a pediatric clinic, miss it by a factor of ten, because they're in a hurry, may be tired. Why not calculate it automatically. It's a trivially simple feature once we've got the data in an electronic system, so we go ahead and do it.

We'll save those, and also jump over to the review tab. We'll just select some recent blood pressures and hit the graph button to graph those. Now this, again, is trivial, once the data is in a computer.

If you ever tried to trend a vital sign or a lab result or something, using a paper chart, health teams often just don't bother to do it, because it's so tedious to leaf through that chart and pull it together. Now that we'll be collecting this data electronically, we can graph it and in some of our live sites, providers have actually flipped the screen around at this point and used this to talk about the

patient's health care with them.

So let's close this, and actually close -- and look at what the note looks like so far. We have gone into a couple of actions, and written parts of the note for today.

This application supports multiple people documenting health care at different locations at the same time. So likely you would see the first few steps in the work flow done by one person in one location, and you'd see later parts of the work flow that are typically done by nurse/practitioners or physicians done later in the work flow. And each one has a date time stamp, and the identity of the user that did that part of the work flow.

They can't actually document simultaneously, even, if they're in different modules. Two people can't document the same module at the same time. This is the rule.

What I'd like to do now is pretend the patient has gone back into the waiting room, or they've been situated in the exam room. The provider now comes into the room to see them. This has been one of the more challenging parts of the application, since providers are interesting people, speaking as kind of one.

We'll open up templates at this point. Often a provider would read the note to this point in time, figure out

why the patient is here today, and then look for a template to document everything else that comes. And the data elements that health teams document for the same condition tend to be pretty repeatable, especially the same provider or the same health team.

There are a list of favorites here, so I can choose from my own favorite list what template I want to use. But notice that under auto search results, the system actually is recommending a URI template, upper respiratory infection template to me. That's because the patient is in here for a common cold.

Because we had a coded data element that said they're here for a common cold, the system can recommend a common cold template to take care of that person. You can imagine where this could go with practice guidelines for diabetes, hypertension, you name it. You can start recommending documentation templates and order entry templates based on why the person is here today.

It's also triggered based on the patient's problem list. Sometimes a person is here today for a common cold, but they have diabetes and they're overdue for their blood sugar check, yearly, or their foot exam or their eye exam. You can actually recommend things based on being on a problem list, in

addition to why they're here today, which is an important safety net for our patients.

We'll just go ahead and select the URI, based on the person being here for that today. Nothing is changed in the note. You'll see all the changes now, as we go through the additional parts of the encounter. We'll click on the SO button. This is a documentation tool.

Actually, I should point out CHCS-II is a component based application. We use robust commercial components, and the work that we do is actually integrating them together; not building the robust functions as much.

So this documentation tool is a commercial component. It's imbedded in CHCS-II. Tracy is going through the symptoms part of the upper respiratory infection, or common cold template, selecting the positive things that the patient has today.

She'll now go to the review of systems folder, and document the things that are positive in the review systems. Typically, these are asked very rapid fire. If you have any headache, nausea, vomiting, whatever, with the patient.

The provider, or whoever collects this, can document the positives, and then when they're done, document the negatives all at one time. Please note that they're not stuck

with a negative. They can click a negative, again, and unselect it, so to speak.

This gives our health team quite a bit of efficiency in terms of documentation speed to document by exception, but not to be stuck with the automatic negative. Okay?

Let's go to the physical exam. Here again, most physical exams are mostly negative. So a lot of the documentation is documenting a bunch of negative things it takes a lot longer to write in a chart, frequently, than it does to examine the patient.

Sometimes with a stethoscope, you'll be listening to two or three things at the same time. So here, the provider can document the few things that are positive, and hit the negative, and fill in the negative things.

Now you'd think, "Isn't this a risky thing, because they're going to document things they didn't do?" It turns out that physical exams, particularly, are very reproducible for a given provider from one exam to the next for the same condition. So the key here is that the tool you see in front of you to document is the same tool they use to build templates.

If they get one physical exam for heart failure, it is their typical heart failure physical exam, they can load

it in their template, and then use that. They're using their own internal standard of documentation as the basis of a template at that point.

Let's go ahead and close out the documentation tool at this point. Actually Tracy's helping me out. We're going to go onto assessment in plan, for the sake of time. Thank you.

The note is actually being written behind the scenes, and I'll show that to you in a minute. Here, what we will do at the bottom, using these different folders, we will take action now on this encounter. This is where we assess what we've determined, and base a plan or even action on that assessment.

Again, because we've activated the common cold template, we've got the things that sometimes result when a patient comes in thinking they have a cold. Sometimes we diagnose common cold; sometimes pharyngitis, sinusitis, acute bronchitis. People might go out with any of these diagnoses when they come in thinking they have a cold. In this case, we'll go ahead and select common cold as the diagnosis for today.

Procedures, also from our template, sometimes we do strep tests from a person, on a person who comes in thinking they have a common cold, if we saw white patches on their

throat. So we'll document the strep test.

Notice -- sorry. It's a little out of focus from this angle. You can see the ICD code on the diagnosis.

I'm not sure if the CPT code is even obvious here, but it's probably obvious in the list. These are ICD and CPT coded diagnoses and procedures, so we're eliminating duplication here.

It used to be that our health teams would do the work, and then they would document in the note what their diagnoses and procedures were, and they'd fill out a super bill, or something that's reimbursement or health system management related, with the same information. Well, here they're entering the information one time, and it writes their note and does the documentation for management and reimbursement.

We can also go over to the medication laboratory order entry, and you can see that the medication order/entry screen that comes up -- this is not just documenting what they ordered, but it's active order entry that we pass back to our pharmacy system.

So again, they're not only -- they're doing the active order, using the computer, and the computer holds onto what they did to write their note for them. So there's not a

second step to document what they did.

You can imagine, this is also a data quality improvement. Whenever you do one thing to do the work, then you do something else to document what you did, you may not document exactly what you did to do the work. By collapsing the two into one, it's almost impossible to document something other than what you actually did, which is a big boost in our data quality.

Let's now go on to disposition. Notice that some of these buttons point backward. We noticed in our work flows that some providers jump between assessment and documentation, back to assessment, disposition, back and forth. So we put the forward and back buttons where people commonly needed them in the work flow.

Here, these are the DoD standardized dispositions on the left. We will say that we want this patient to follow up as needed with their primary care manager, me. Being a pathologist, this is a very unfortunate patient. And that we want them to follow up -- I'm having trouble reading the screen.

We discuss the diagnosis with the patient. It's important to put this here as a reminder in the work flow, to talk about the patient -- talk with the patient about what

comes next. When do you come back?

It also keeps the joint commission very happy to have this documented well. And it was put here for both reasons, actually, as a reminder and to get it documented well.

Many clinics have a rubber stamp for this, so they are sure they cover the right pieces of information with the person as they go out of the clinic. So we put it here.

I mentioned that Tracy is putting in the disease, non-battle injury codes. These are the two data elements that are here, because this laptop is intended to be in a tent, in a theater of combat, and we collect disease/non-battle injury codes to categorize injuries in combat, and we're just forced to put them in here.

What I want to point out though is, the bottom half of this screen, the tool that you saw earlier with the pluses and the minuses, where we documented symptoms, physical exam findings, is just another view of this same tool. This view of that same tool, that same data set, is adding up the history data elements, the review of systems, the physical exam data elements, and calculating a valid evaluation and management code, a billing reimbursement code.

So this is a huge step forward for us. It used to be that our health teams would document the care they

delivered, and then take their best educated guess at what the reimbursement code is, for what they documented. We're running that work flow the other way.

Based on what they actually documented in that health encounter, the system will calculate the E & M code. So what we have to do then is get this tool correct one time and keep it correct as the reimbursement rules change for calculating E & M codes. By the way, since this is a commercial product, we don't do that maintenance. We lean on the commercial vendor to do that maintenance.

We don't have to back verify those codes encountered by a counter, with a coding professional. The system is calculated to write reimbursement code from the note that we wrote on screen.

Let's go ahead and close at this point. I'd like to show you the note that's being written behind the scenes. So the principle is, we've automated the steps of the work flow.

We have the system hold on to all the data that's collected as a by-product of the work flow, to write the note for the provider. And by the way, all those data elements are stored in the data base with concept identifiers behind them. I'll show you why that's important in a little bit.

This is a note. And I just heard a story from on of

our live sites the other day that a patient came into the emergency room, and the note printed from this system, even though we're not live in the emergency room, the note printed from the system was in the chart when the patient got in the emergency room.

The next day the emergency room provider called the primary care provider and said, I have never seen a note that was that legible. Just a nice little anecdotal benefit.

So even in places where the system isn't yet, it has benefits in terms of improvement of health care efficiency, and potentially quality. Anyway, this is what the note looks like. Again, it's very human readable. Where do we go next, Tracy? Signing?

What we do, when the person responsible for this encounter hits the "sign" button, we actually lock all the modules in the application, and bring them up in a scrolling window, so the provider can scroll this note up and down and see exactly what they're signing at that point in time.

This is important, because if someone down the hall just got around to transcribing the blood pressure from their -- the scrubs on their leg into the computer, a second before I hit the button, I need to be able to see that blood pressure to be accountable for it.

If they didn't get it entered until a second after I hit the sign button, it wouldn't be in my note yet, because I couldn't possibly have seen it. What we do is show exactly what I saw and what I'm accountable for.

I put in a password to sign it -- and by the way, we have role-based security. So it's the role-based security that lets us use the same software at the front desk, and the nurses station and in the provider's exam room, but the front desk clerk can't browse through notes, for example. They have no business looking at clinical notes.

The same role-based security allows us to know if we're dealing with a health care provider who is supervised. If we are, we force them to identify their co-signer, their reviewer, and we drop this encounter into the co-sign folder of their supervisor. This is a huge step forward for us, in terms of closing the loop on records and charts.

Let's go ahead and close this now. That really is most of the live part of CHCS-II. I spent a lot of time on the work flow showing you how a data set is really a by-product of automating a work flow, which is a huge step forward for us.

I'd like to show you why people like the joint staff approve money to automate systems like this. They care about work flow. They care very deeply about patients. But they

really care just as much about data, and what we can do with data.

So I'd like to take you to this next slide, and show you that based on the structured data we're collecting, again as a by-product of the work flow, that we can run rules in the system, not only for the people -- these are the people who are the right age and the right gender, that they should have a mammogram done. But because lab results are also coded, we don't bother to put someone on the list if they had one within the last year.

So we can start to get some of those rules to support the health care process, rules that cancel themselves if they've already been fulfilled by other data in the system.

The next slide shows us really what our big brother sponsors are interested in. As we take troops into training situations, and we've got them being injured by heat or dehydration, we want to be looking at those symptom clusters.

We documented the physical exam findings, and the symptoms the patient complained of as discreet data elements. So now we can mine those.

A person doesn't complain of palpitations, and it's PALP in this note, and full palpitations in that note. Behind the scenes, there's a number corresponding to palpitations that

we can mine as a structured data element out of the data base.

We had trouble with dysentery in Bosnia. And you can imagine with an outbreak and people that are deployed, it might be this point in the outbreak before we even recognize in the data rollups that there's a problem.

Well, if we can roll this data up electronically and aggregate it with those numeric concept identifiers, we may be able to recognize the outbreak days earlier, and intervene, getting our public health teams out to look at food and water sources, and correct the problem sooner.

Actually more troops are taken out of combat by illness than by bullets and bombs. So this has a huge impact for us, in terms of maintaining the readiness of our forces in the field.

This last one is interesting, because we actually put in the notion of looking for symptom clusters that could be consistent with anthrax. This slide was put together before September 11th of last year, because the DoD has cared about things like anthrax for a very long time.

And probably this is even more relevant now that there is at least a hint of a threat of smallpox being released, again, because every -- literally every hour that we would gain, detecting a release of something like smallpox,

would be people not getting on planes and passing it around the world. So this is the part that is probably the most relevant from a large scale population health perspective.

Some have speculated that the DoD may actually become a bit of the canary in the mine for the rest of the Continental United States. Because with systems like this, we may detect a disease outbreak before anyone else has the automated systems to do that, because we have people spread around the country. That's out on the fringe of speculation a bit, but the tools will do it.

That is everything I have on CHCS-II. I've tried to keep it moving along, because I think this is mostly an FYI type presentation. And we're ready for questions, if you have any.

MR. REARDON: We have about five minutes for questions.

MALE VOICE: I'll be short. I promise. Pardon me, I didn't get your full presentation, and I didn't understand if you, being at your website and looking at a couple of different things. Are you still dumping all your data into EIDS?

LTC. HARMON: The structured data that results from this work flow will go to EIDS. The initial data that's flowing to EIDS is the structured data we've collected for a

long time. So diagnoses, procedures, that type of data.

Longer term, though, I think it's likely that we'll start feeding also the structured symptoms and physical exam findings to data warehouses. Whether those are EIDS per se, or not, I have no idea.

But we've actually even had the Centers for Disease Control interested in the data that we're collecting, because they see a tremendous value in this kind of data for population health reasons. But I can't speculate on when we would do that, or what system it might be populated into and mined out of.

MALE VOICE: Right. And it's a sub --

MR. REARDON: The answer is yes.

LTC. HARMON: Yes.

MALE VOICE: Okay. Thank you.

MR. REARDON: Any other questions? Okay. Well, thank you very much, Dr. Harmon.

The next part of the presentation will be on CHCS-I, the Composite Health Care System.

The people who are coming up, we have Lt. Col. Tony Smith, and we have Dave Metcalf, and Dave Metcalf is the Senior Vice-president with SAIC, and we have Hector Rodriguez, who is the manager of a software development team, at SAIC.

Lt. Col. Smith will be going through CHCS-I for us. And particularly he's going to focus on the PCM by name portion of the system, which is a new capability they've implemented to support primary care issues. So with that, I'll turn it over to Col. Smith.

LT. COL. SMITH: Hello. I was asked to give a brief overview of CHCS. It's been around for a long time. And you've seen many of the changes that are coming about in the near future.

It has been the primary automated information system for DoD since the early '90s. It is one of the largest across the world. It is deployed across 120 hospitals, 102 hosts that support 120 hospitals, and over 530 clinics. It also serves approximately 150,000 health care professionals in those facilities.

It enables the providers to provide access and document care for over 800 million beneficiaries. And as you can see, it was designed in the early '80s and deployed worldwide in '95.

Much of the technology in the scroll base issues that you've heard about in CHCS, when they were -- they were state-of-the art back in the '70s and '80s. Now our requirements expect a lot more.

I want to also point out the fact that CHCS is working in concert with the VA on several projects: one being the GCPR, the Government Computerized Patient Base Record; laboratory inner-operability and data sharing initiatives.

Lab Interop will allow us to pass data from the civilian labs into the CHCS, and back. If we want to go to HIV and have that kind of data passed on back to the civilian lab, we can gather that information back into CHCS.

And also we have a project this year working with the Consolidated Mail Outpatient Pharmacy module called CMOP.

Just to give you an idea of how much of a workhorse the CHCS has been for the enterprise, it supports over 300,000 users worldwide, and in the neighborhood of 32 million plus outpatient visits per year.

It deals with roughly 800,000 inpatient admissions per year. And for those that deal with the bed days, it supports over one million bed days per year.

It is up, operational and available for the sites, worldwide, 99 percent of the time. We do have some planned down time for support and maintenance pieces, but otherwise, it's been a work horse for the enterprise.

I just want to point out that we've had actually online, order entry available since early 1991 time frame.

Report functionality, there are about 17 items listed here on the slide. This is just an example of what's in the system, and what we've been able to provide for the enterprise.

It covers everything from provider order entry to dental to radiology to supporting problem list, consults, billing, third party collection pieces, and the PCM by name changes that were made this past year. Next slide.

Some of the functionality where we've had significant enhancements in the past year involve the enrollment and eligibility that you all are aware of, and the National Enrollment Database, NED, that came about last year.

The enrollment data synchronization projects: we're working with multiple ways of trying to synchronize our data, within our fifty plus interfaced systems that we connect to, including CHCS-II.

We've done a lot of work this year on PCM by name, and the direct care piece of network physician PCM assignment. The PIT message is an automated process we haven't had in the past.

The PCM panel management: we can look at capacity management, and batch reassignment pieces. We've been doing it one at a time, and now we have the functionality to do a batch reassignment.

The third-party collections, if you don't know, we went worldwide 1 October to support line-item billing for the first time. That was a major success so far. We went worldwide in 24 hours.

Some of the data centralization issues, policies and regulatory requirements that we're working on, that affect this project: we are in synchrony with DEERS and ongoing new requirements. We have appointment standardization that we've been working on as well. The appointing piece has been a troublesome issue. We're trying to standardize that piece as well.

LOINC is the laboratory data standardization piece that we're trying to standardize lab files across all the enterprise and the Standard Insurance Tables, SIT, that you are aware of.

Some of the additional tables that you see listed on the slide: CPTs, ICD-9s, CMAC and the First Databank, FDB, was the support for pharmacy. The UIC, the DMIS IDs, and the PATCATS, just to name a few, all support CHCS.

And this year, we're working on the HIPAA requirements. We have funded requirements to work on the X12 provider taxonomy piece. The eligibility queries of 270, 271, and the claims processing at 837, and several others.

This is what Mr. Reardon referred to earlier, as far as the PCM by name changes that we're working on. The first piece that was mentioned earlier today, that will allow PCM by name batch reassignment functionality to be accessed through web view portal. This will activate the software to initiate PCM reassignments.

The next piece is that DEERS is becoming the repository for PCM by name information. In support for the PCM by name, assignment for the direct care beneficiaries, we added the interface. The opportunity to send batch PCM assignments from DOES sends reassignment changes back to DEERS, and to allow the PCM changes across the DMIS IDs within a host.

For those that have been dealing with this issue for the past year, year and a half, it's been a trying experience. So hopefully this automation will support and improve that process.

The PCM changes also address the UIC codes, the provider codes, the gender codes and age. These are all new functionality pieces that we now have available. And then the last piece that I have there on the slide is to add the provider type code for resource sharing to support this initiative for the provider file, and CHCS.

Now, hopefully you can see this diagram. The boxes

on the -- the orange box in the corner is CHCS MTF, and the interface, as it interfaces with DEERS, you see -- I can't read the screen from this direction -- the enrollment --

The interface between CHCS and DEERS, the DEERS in green. Then the top left corner is the DOES. DOES is what you heard about this morning, was the access into getting the information from DEERS.

The MCSC, the blue box -- the box there, where the pointer is, will interface with the -- sorry, I've got to get closer to the screen.

(Speaking away from microphone) You'll notice the information from the EIT (inaudible) --

Thank you. Is that better? The MCSC header, the EIT block, it is information being passed from DEERS back to MCSC. The interface between DEERS, the pit messaging is involving this sponsor of interface sharing information, and mailing address, phone number information, being passed back to CHCS.

The eligibility inquiry is going from CHCS to DEERS and back to CHCS.

The patient updates is below -- is the address, phone number, blood type, organ donor information are being passed back to DEERS.

The top left hand corner, the DOES block, represents

the inquiry, the enrollment addition to transfer information and PCM assignment, disenrollment information, enrollment changes, address changes, OHI and fee changes will be communicated as well.

I realize this is hard to see. It will be on the web for downloading for viewing later.

I know this is rather quick, but it's basically to provde an overview for CHCS. The focus here has primarily been on DEERS, and how it's changing, and how it will affect your business processes.

CHCS is behind the scenes providing all the information, until we find other solutions like Tricare Online to provide other functionality for the system.

And I'd like to open it up for any questions, if you have any, as it pertains to CHCS.

FEMALE VOICE: (Speaking away from microphone) I have one. (Inaudible)

LT. COL. SMITH: Can you go back to the diagram.

FEMALE VOICE: Your EIT interface from CHCS to the managed care subcontractors system. What is that?

LT. COL. SMITH: Yes. Actually that line indicates that the EIT message comes from DEERS, as it currently does today. It's actually not a transaction initiated by CHCS.

MR. REARDON: Questions?

LT. COL. SMITH: Anyone else?

MR. REARDON: Okay. Well, thank you very much, Col. Smith.

What I'd like to do is take five minutes, in-place break, and get Mr. Pete Koste up here.

[Break taken.]

If we could take our seats again. I appreciate you giving us a couple minutes to get the technology straight. We're ready to go.

MR. MEEKER: We've had several questions regarding the slides and their availability. Just so you all know, the slides will be available on the web site. They will be posted, along with the answers to the questions. So if you need those, you can go to the web site and get those.

MR. REARDON: Our next presentation this afternoon is going to be on duplicate claims. And let me just thank Pete Koste, before he comes up and does his presentation, for all of the work he's done, not only in supporting us today, and this afternoon. He's a fountain of knowledge on this subject.

Also, Pete has been extremely valuable and important in pulling all of the requirements together. All of the

information technology requirements together, to assure that when T-NEX is ready to go into full operation, the technology will be there to support it. He's done a wonderful job on it, and I really appreciate his efforts. With that, Pete, if you would --

MR. KOSTE: Thank you, Mr. Reardon. I'd like to introduce Mr. Dick Parker, who will be manning the keyboard over there for me, as we go through this presentation, and through the demo.

I'd like to provide you with some information regarding the duplicate claims system today. I'm going to try to go through this fairly quickly, since we're fairly limited on time.

But I want to give you a feel for how this system operates, and what, as bidders and future contractors, what you're going to be required to do, in terms of running this system. Can we take a look at the agenda, please?

I'd like to go through this by providing an overview of the system, a little bit about the data in the duplicate claims systems, some of the requirements, and actually get into a short demonstration of the system. Next slide.

Once upon a time, there was a claims processor that paid a duplicate claim. Now, I know that doesn't apply to any

of us here in this room.

But just in case, we built the duplicate claim system. And the duplicate claims system defines a duplicate claim -- and I'm not going to read it to you, because you're able to read it for yourselves, but it's fairly straightforward. Next slide, please.

The duplicate claims system is used for the identification, resolution and verification in reporting of potential and actual duplicate claims payments. It identifies two types of duplicates. Not only those that you actually have to go out and recoup dollars on, but it will also identify duplicate payment records in our HCSR data base, and in our TED data base.

I'm going to talk a little bit about what we refer to as HCSR dups and TED dups in a minute, because it's an important concept for you all to understand, as you go into this bidding process. Next slide, please.

The system right now, currently as it's deployed is a stand alone realtime client server application. We are developing it and will be deploying it as a web application for the T-NEX contracts.

Right now, in production, we have a HCSR version of the Tricare Duplicate Claim System, but for T-NEX, there will

be both the HCSR and the TED versions.

We believe that the system is and has a user friendly interface. And we believe there are minimal data entry requirements within the system.

It's a very flexible system, in terms of how you can deploy it, and you can structure how you use the system to meet your business practices and processes. Next slide, please.

It's important that people recognize that what we're talking about in the duplicate claims system is a retrospective system that uses HCSR and TED data. We do not interface with the contractors claims processing systems. We are not using contractors claims history records themselves.

What you're looking at in the duplicate claims system are net records, net TED records or net HCSR records. That's really important for you to understand.

You can think of HCSRs and TEDs for the purposes of the dup system. You can think of HCSRs and TEDs as entries in the government's checkbook. Next slide, please.

I'll talk about that in some detail in just a minute. But before I do, I want to tell you that the DCS identifies institutional and non-institutional duplicate payments, potential dups and we use five sets of criteria to identify those out of the HCSR database and out of the TED database.

We have exact match, near match, data overlap, CPT match and other match. For institutional claims, we identify them using an exact match, near match, data overlap, and other match criteria. For non-institutional, we use exact match, near match, CPT match, and other match. All of those criteria sets are in the operations manuals in Chapter 9 and 10. You can find them there.

What we do to identify potential duplicates to display to you, to work, we compare the current months' HCSRs or TEDs against 12 month collection, if you will, a base file, of the previous HCSRs and TEDs that were submitted. Next slide.

Every month we go in and we group the potential duplicates that were identified by those criteria sets into sets, and we load them to the system.

On a daily basis, we sweep all of the HCSRs or TEDs that were submitted to us, looking for adjustments that apply to any of the claims that are already residing in the duplicate claim system. When we identify those, we then attach them to the duplicate claim system set, where they're accessible to the user and you can work them. I'll show you how to do that in a minute.

The one thing that I think is a pretty unique feature of this system is, we're identifying potential duplicates that

occur when two different contractors pay the same claim. So if you have contractor A paying the claim, and then have contractor B paying the same claim, neither one of these contractors know that the other paid it.

Our system will put those two claims together and allow you to see that. In every single multicontractor set, which is how we refer to those sets, there is then a jurisdictional error committed, and there is always a -- there's always a duplicate payment involved. Somebody's going to have to recoup those dollars. Next slide, please.

Okay. I'd like to talk for a minute if I could about HCSRs and TEDs and in particular, TED records, and thinking about these records as entries in our checkbook.

When you process a claim, you're going to be sending us a TED record. That TED record is going to tell us what you did with that claim, how you processed it. If you say to us that you paid $100 on this claim, that entry, or that TED record, is like an entry in our check register.

If you send in another TED to us that says we pay $100 for this same service, for this same beneficiary, it looks to us, if we think about it as our check register, as if you paid $200 out the door.

We will group those two TED records into a set, and

we're going to show them to you, and we are asking the question by displaying these to you, is there a duplicate claim here? Was a duplicate payment made?

You're going to go into your claims processing systems, and you're going to research those two claims that we show you. And you're going to determine whether or not one of them, or none of them, were actual duplicates.

If you, during your research discover, well, we only sent one check out the door, and that check was for $100 and it was on the second claim. We never sent a check out on the first one. You might be inclined to say to us, in the duplicate claim system, this isn't a dup. We have no dup here.

However, by virtue of the fact that we're showing you two TED records in the duplicate claim system, what you've done is, you've told us $200 did go out the door, and we have no idea from the TED record whether a check really went out the door or not.

So for us, that overpayment, if you will -- looks like an overpayment to us in our check register -- requires the same kind of action as what you would have to do if you were going to void a check in your own check register. We need an adjustment TED record that cancels that first claim, assuming that there wasn't any payment that went out the door. Okay?

If you got a refund, if it really was a duplicate payment, and you received $100 back, we would also expect to see a TED adjustment coming into us that would reflect the receipt of that $100, which would in essence cancel out one of those two claims that were in the set.

So what we've done is, not only collected the money, we've also corrected a duplicate condition on our payment record database, which is absolutely critical, because if we start trying to plan programs, if we start trying to figure out exactly how much did it cost us for health care in this particular region or this particular time, if all of that data is inflated with duplicate TED records, or duplicate payments, obviously we can't do very good planning. So the duplicate claim system is a very important part in our efforts to maintain the integrity of our data.

The T-NEX managed care support contractors are going to inherit HCSR sets from the outgoing managed care support contractors. They are going to inherit the not-at-risk sets.

Not-at-risk sets are government dollars. We can't just say "Forget about it." If government dollars went out the door, and they were erroneous overpayments, we have to get that money back.

So what will happen is, we will identify, in accordance with the transition schedule, a certain point in time where we're going to migrate all of the not-at-risk claim sets, duplicate claim sets, from the outgoing contractor to the incoming contractor.

At the same time, the new contract, new T-NEX contractor is going to be processing their own claims and submitting TED records. When they submit TED records, we are going to be -- and if there are any potential duplicates that we identified during the course of processing those TED records, we are going to display those in the TED version of the duplicate claim system.

Now, it's the -- as we go through this transition, there's going to be fewer and fewer and fewer HCSR sets that are going to be created, because we're obviously migrating into T-NEX contracts, which are solely TED records. So at some point in time, the HCSR version will go away as soon as we have resolved all of the not-as-risk claim sets, and we've finished the transition from the managed care support contractors currently to the T-NEX regions. Okay. Next slide, please.

There's only one performance standard in the duplicate claim system, and that is no more than ten percent of the potential duplicate claim sets remaining in open status at

the end of a month shall have a current load date over 30 days old. Translation of that is, we want you to work these sets on a first-in, first-out basis.

You'll see in a moment what we mean by open status and what load dates are. We'll show that to you as we go through the demo.

The way the performance standards are measured, there is a built in, pre-formatted report that everyone has access to in the duplicate claim system. You can run that report and you can see what your percentage is, how they are at any point during the month.

We have a whole array of pre-formatted reports in the dup system. As a result of the fact that we are all seeing the same data and have the same access, there is no separate reporting requirements for the contractors to submit reports to TMA. We can get our own reports out of the system the same as you. Next slide, please. Let's fire it up.

When you first log on the system, you come to this main screen. You'll notice there's an active database, a history database. There's a training database and an exit button. We're going to go into the training database.

Active database is where the production work occurs. History database is where you can go back now and find all of

the archived sets that belong to you.

Now it's important to realize, too, that not every contractor can see the other contractors duplicate claim sets. Contractors are only able to see the claim sets for which they have permission. All right?

In today's environment, Region Six, can't see Region Nine, Ten, Twelve duplicate claim sets, and vice versa. We segregate them.

Go through a little geography lesson. At the top of the screen, you have a tab that says "Non-institutional." That will change to "Institutional" if you're looking at an institutional claim set. Each set is uniquely numbered. There's no two sets that have the same number in the system.

There're statuses in this system. And remember in the performance standard I pointed out a moment ago that we were talking about sets in open status. There are four statuses in this system. Open, pending, validate and closed.

Open and pending are the two working statuses of the system. Validate and closed are the two resolved statuses in the system.

Open is simply, there hasn't been any work done on this set. That's pretty straightforward.

Pending doesn't mean pending action. It means

pending recoupment. It means you've identified some dollars for recoupment and you're out there trying to get the dollars back.

We'll move on here. This will tell you at the top, in terms of the set information, what was the match criteria against which this set was created. In this case, it was exact match.

It will tell you who the owner FI is -- and we use the term "FI" in this case so we didn't have to spell out managed care support contractor on the screen; save a little space. Means the same.

We'll tell you who owns this set. What region.

If we go down below there, you'll see the initial load date and a current load date. For the performance standard reports, we use the current load date. And there's some reasons around that; the load date can change. I'm not going to go into that kind of detail today.

Underneath those dates, you'll see that we're on, what is it, set 15 of 111, so you can -- as you move from set to set, that will change.

You'll see a stack of three red numbers. These are the numbers that the system uses to resolve a claim set.

A user cannot go into those fields right there, and start changing data. The only way they can change data is in

the data entry fields at the bottom of the screen, and I'll show those to you in a minute.

You have an ID recoup field, an actual recoup, and an adjustment amount field.

You also have a resolve-the-set button. Pretty straightforward. When it's time to resolve this set, press that button, and the rules of resolution will be invoked, and determination made as to what status this set ought to go.

If we go to the lower part of the screen, you'll see -- this is the information about the claims that comprise this set. Now, you'll see that there isn't a whole lot of information there.

Down at the bottom, you'll see a number of tabs there; four tabs in this case. There's a set tab, which means we're on the set screen right now. There's a detail tab. If you click on that detail tab, this will provide you all of the claims information that is involved in these two sets. In other words, all the information that we received on your TED record that came in are on these two TED records.

You go through it. This was an exact match. All of these fields are lining up, in terms of being exact duplicates. Okay?

This is a non-institutional claim set, and as a

result, non-institutional claim sets have line items. If you click on the line item screen, you'll see that on this set, or in this set, we have four line items. Two for each of the corresponding claims.

Right now it's in ICN, or claim number order. If we put some functionality here, so that you can sort these line items, then you can more easily see how they line up. So you can see that two line items are for $13.04 and another couple for $117.08. That's why we're presenting these to you, because in our evaluation, those look like dups to us.

If we go back to the set screen, this is where we start asking the user to start entering some data. You have to indicate to us whether or not one of the two of those claims are a duplicate. And they do that by researching in their own claims processing system, as I mentioned earlier, is it a dup or isn't it? Let's in this case say it is.

Puts a "Y" in that dup flag field saying that 200 ICN claim, and I'm going to refer to it as the 200 claim, because it's the last three digits of that ICN. We're saying that's a dup.

We ask the contractor then, if they're saying "Yes, it is a dup," to give us a reason why it's a dup. You double click on that, it'll give you a whole laundry list of potential

reasons.

If you don't like any of those reasons, there's an "Other," at the very end that you can pick. But it's not that easy. If you click "Other," you have to explain what that "other" is.

You'll also notice that when you put the "Yes," in there, it automatically identified a recoupment amount. Now, how did it do that? Go back to the line item.

If you'll notice, it populated the dup flag field for those line items that were associated with that claim. Did that automatically.

It took the government paid amount, that's at the line item level in the TED record, which is the difference between the TED version and the HCSR version. You don't have that government paid amount on HCSR.

It took that government paid amount, and it said, "Okay, we're going to go out and recoup $13.04 on that one line item, $117.08 on the other." It added the two together and it put the ID recoupment amount for you at the very top.

Go back to the set screen, please. We're going to update those changes, and I want you to watch the status. It changed from open to pending, meaning pending recoupment. Why? Because we said we identified $13.12 that we need to recoup.

So now you go and you do your recoupment action, and in comes the check. Yay, we got $130.12 back. The user has to put $130.12 in. You can update the set, again, if you'd like to. You'll notice nothing changes. Now, why is that? It's still pending. Because we have not received, if you will -- pretend that you don't see that adjustment flag -- we haven't received the adjustment yet reflecting that $130.12 recoupment that you just got.

A couple days later, in comes the adjustment that you sent to us, the TED adjustment, reflecting the $130.12 refund that you received. You'll hit the adjustment. There they are. $13.04 and $117.08.

You put a couple of "yes's" in there for the TED adjustments that apply. You'll notice the three red numbers up there, $130.12 three times. They all line up.

That means we actually got back what we identified for recoupment, and we have adjustments in our database that cleans up the duplicate condition. We hit the resolve-the-set button. It goes to a closed status.

Now there's a lot of bells and whistles in this system which I don't have time to go through in here, to show you, but for now, I mentioned the reporting capability. There's a whole pile of reports in here that are preformatted.

And if you hate our reports, and you just can't stand them, we also built in the capability for you to download all of the data that you want to download for your region or your contract, and it'll come down in ASCII fixed line formula. You can pop it into Access or in Paradox or in Excel, or wherever you want to manipulate those data, and create your own reports.

We built a mini-report generator in here. You can start setting some parameters or filters for the report. In this case we were on set 121, so I guess -- what did you do, went 120 to 123? As a set range, say "Yes. There's one of the reports, top right.

You can change a password in here. There's notepad capabilities. You can read "reason code," "reasons," there's all sorts of stuff in here. But that's essentially what's involved with the duplicate claims system.

But now, that looks pretty simple. The hard part about this is doing the research, and remembering what you're looking at. Because when you're looking at this system, and you're turning around to your own claims processing system, and you're looking in there and say, "I don't see where I paid that dup. It's not a dup."

You've got to remember that you're looking at TED data. And what you're looking at is our check register. You

sent us two entries. Now we've got to get cleaned up.

Sometimes it means actually going out and getting dollars, and other times it means just sending us the adjustment because something got screwed up, and we got those two and one wasn't cancelled.

Okay. Can I answer any questions?

MALE VOICE: Pete, I think I understood the entire demo. I just had a question about who's actually doing some of that screen entry?

Now, the screen entry has actually been done by the managed care support contractor. Does that also include updating when TMA is actually receiving the final TED record on the recoup? Or is that being done by TMA?

MR. KOSTE: No. If you're entering the data, as you're doing your research into the dup system, okay? When you get the refund back, or when you determine that you need a TED adjustment to correct a duplicate condition, if it's one of these TED dups I was talking about, then it's up to the contractor, obviously, to send that in to us.

MALE VOICE: Right.

MR. KOSTE: We process it during the normal course of business, and every cycle, we look for those adjustments. We pull them out, once we find them. Then we populate the set to

which that adjustment applies.

And that adjustment flag down at the bottom, or that adjustment tab will appear, and that makes it accessible to the user back at the contractor shop to resolve the set. We're not going to go in and resolve the set for you.

MALE VOICE: So it's still up to us to --

MR. KOSTE: Yes.

MALE VOICE: -- resolve that and close it out timely, and making sure that you've processed that TED for the --

MR. KOSTE: What we're asking you at that point, we have your TED adjustment on our system.

MALE VOICE: Right.

MR. KOSTE: What we're asking you, at that point to do, is to resolve that claim set within the duplicate claim system.

MALE VOICE: Right.

MR. KOSTE: Okay. Now, we don't do that automatically, a the reason why we don't do that automatically, in part, is because we get -- you can send in a number of adjustments to a claim as you know.

MALE VOICE: Right.

MR. KOSTE: You can send in positive and negative adjustments over and over, again. We don't want to stop that

process and say, okay, "Well, this is the one that really counts," because ten minutes later in could come another one that undoes what you just fixed with the adjustments.

So we want you to consciously go into the system and say, that's the adjustment that applies for this refund, or that's the adjustment that applies to correct the TED dup.

MALE VOICE: Understand. Thanks.

MR. KOSTE: Thank you, sir.

MALE VOICE: Just a couple of clarifications. On one of the slides, you said that the T-NEX winner will inherit all open, not-at-risk sets. Talk to me about TFL.

MR. KOSTE: Yep.

MALE VOICE: You get those, or they go somewhere else?

MR. KOSTE: No. The Tricare For Life claims, or sets, it's our intention to send those to the dual eligible FI contractor. So those will be taken off of the T-NEX contractors.

MALE VOICE: Thank you. On TEDs --

MR. KOSTE: On that, by the way, let me add one other thing. That means that all of the T-NEX contractors that you're going to have to be dealing with HCSR records and for the dual eligible contract, have got to have the capability to

be able to read HCSR records that are coming, copies of which are HCSR data that you may be receiving in the transition from the outgoing to the incoming.

MALE VOICE: Sounds complicated.

MR. KOSTE: Yes, it is.

MALE VOICE: But I'm sure it'll be easy.

MR. KOSTE: Piece of cake.

MALE VOICE: Yeah, right. On the TEDs, when the TEDs become the son of HCSR, and HCSR kind of goes away, you talked about -- how will you compare the first months of TEDs? Are you going to look back and compare it to 12 months of HCSRs, or will --

MR. KOSTE: No.

MALE VOICE: -- there be one going forward and build the population.

MR. KOSTE: We're building as we go. We're not going to compare TED records to HCSRs.

MALE VOICE: Okay. And the last question, do you have any statistics that would tell us what are the false positives that the system produces?

MR. KOSTE: Well, our system doesn't produce false positives. Remember, you're sending us. We're looking at your data. I don't stay up at night creating these things to send

to you.

I will tell you that it can go from -- we've seen anywhere from 60 to 70 percent of the sets that we've put out there, depending on the month, be actual duplicates. And that doesn't necessarily mean actual duplicates with hard dollar refunds. That can be actual duplicates with a combination of hard dollar refunds, and the correction of HCSR records that needed adjustments.

MALE VOICE: Thank you.

MR. KOSTE: And we've also done a lot of work to try to -- we're not showing you all the potential duplicates, by the way. If we did, that's all you'd be doing.

So we've done a lot of work to try to refine that criteria with the contractors, and are, in fact, undergoing a study right now with looking at the modifiers, particularly around Tricare For Life claims.

FEMALE VOICE: Pete, let me just make sure I heard what you just said. You said that the outgoing will finish processing HCSR. Incoming starts processing with TED, but there are several months where we are doing dual processing between the incoming and outcoming. Does that mean the system won't capture an outgoing contractor who processes a claim, reports a HCSR?

MR. KOSTE: What's going to happen is, if you look at the transition schedule, back in Chapter 9 and 10 of the Ops Manual, there's separate transition schedules there. But essentially, we've laid out month by month what has to happen.

At the beginning of the fourth month, following the start of health care delivery, it's at that point that we are going to do what we call a mass change.

It's at that point, we're going to take all of the sets that belong to the not-at-risk claim sets that currently belong to the outgoing, and we're going to assign ownership of those sets to the new T-NEX contractor. At that point, the T-NEX contractor is going to see all of these HCSR sets in the HCSR system.

There is a point where we are -- once that happens, once we do that mass change, you're to stop processing any duplicate claim sets in the HCSR system as an outgoing contractor. All right? Because every time you send us another HCSR that dups out with another HCSR in the dup system, we're going to find that, and that ownership is going to be changed over to the incoming.

So there is a point where, because we are not comparing TED records to HCSR records -- this starts getting really complicated -- because we're not doing that, we're going

to miss some dups. I mean there is no way to do this without missing some.

But we've tried to minimize that through the transition schedule laying out exactly at what point each contractor, outgoing and incoming, has to do, in order to bring these systems in line.

There are times when, for instance, a timing issue -- remember I said on the first day of the fourth month, we're going to transfer all of these sets over? We don't do the monthly run until we have the full set of HCSR records which can occur after the 1st of the month.

So we might process that third month's worth of HCSR and TED records -- or excuse me, the HCSR records -- 3rd or 4th day after the 1st of that 4th month, which means all of a sudden the incoming contractor is going to see some more HCSR sets, the ones that we didn't know about when we sent -- did that mass change and sent the responsibility over. I'm trying to answer two questions at once here, but --

FEMALE VOICE: Okay. That means that the incoming contractor, when you said needs to read outgoing contractor's HCSR, that is really to satisfy the business need of -- you still have to determine whether or not it's a dup or not?

MR. KOSTE: Right. And so your claims --

FEMALE VOICE: You have to look at out- --

MR. KOSTE: You're right. The outgoing claims history has got to be able to be read by the incoming contractor.

FEMALE VOICE: Right. Got you.

MR. KOSTE: They've got to be able to know what HCSR data is out there, so they know what was sent. And to that extent, you have to have that capability.

FEMALE VOICE: So when we are --

MR. KOSTE: But you don't, as an incoming contractor have to send HCSR adjustments.

FEMALE VOICE: Okay. Because we are sending TED adjustments to a prior HCSR?

MR. KOSTE: That's right. You'll be submitting a TED adjustment for a prior previously submitted HCSR. We'll do that translation and do the adjustment in the HCSR system, and you'll see that adjustment there.

MR. REARDON: Other questions? Thoughts, comments.

Again, I'd like to acknowledge the outstanding efforts on the part of Pete, and everything he's doing for T-NEX. He is really the glue holding us together, in my opinion.

What I'd like to do is, we switch off some technology now, take a five-minute break. We have one more presentation.

I appreciate your perseverance here. The good news is, we're 40 minutes ahead of time. So give us five minutes, and we'll be back to do something on DITSCAP.

[Break taken.]

MR. REARDON: Okay, folks, if we could take our seats. That would be much appreciated and we'll get rolling with the last presentation for today. The briefing today -- Gary, if we could close the doors.

I do appreciate the fact that we still have quite a few people here now.

The next briefing today, and the last briefing today is one that there seems to be a lot of interest in. We're going to talk about the Department's Information Technology Security Certification and Accreditation Process. It's very important within the Department, as you can well imagine, that we secure and accredit all of our information systems.

Dorothy Williams is going to present the briefing today, and she is the MHS Information Assurance, or the Chief of MHS Information Assurance, which means that she has an important responsibility to make sure that the Department's guidelines on security and information assurance are followed.

What Dorothy will be presenting today is the Department's policy on protecting information and protecting

our networks. Dorothy doesn't make the policy, but she's going to lay it out in what I think will be a very comprehensive and understandable format. We've already had quite a few questions on this, and we'll take some questions at the end of Dorothy's presentation.

Then I think it's safe to say that we'll take all of your comments, your thoughts, and your recommendations, and bring them back and sit down and decide how best to move forward, as DITSCAP, as we refer to it, relates to the T-NEX contract.

Dorothy has done a great job, in the last year and a half, moving the program out. And as the Department in the last 12 months has spent quite a bit of time in strengthening its security posture, Dorothy has been the lead for the military health system in doing that, and has been an outstanding representative for the military health system, and an outstanding representative for our partners, the MCS, Managed Care Support Contractors.

She's working with many of you today, as she visits each of your sites, and works through a process that will achieve either an interim or authority to operate under the defense guidelines. So I'd like to thank Dorothy for everything she's done in the last year in this program.

And I'd particularly like to thank the managed care support contractors for their willingness to work with us on this very important matter. So with that, I'll introduce Ms. Dorothy Williams. Dorothy.

MS. WILLIAMS: Good afternoon, everyone. I'd like to talk to you today about DITSCAP requirements as well as the ADP requirement that DoD has in place.

The purpose of the first brief I'm going to give you is to go through the overview and give you a little insight into what the DoD requirements are for DITSCAP.

DITSCAP is basically the process that DoD uses to insure that AISs and networks -- and throughout this brief, when I refer to "Systems," I'm referring to AIS and Automated Information Systems and Networks.

It's a process the DoD uses to make sure our systems have the security requirements in place to protect the information that we are managing.

DoD uses DITSCAP to ensure that any information that is transmitted, processed, stored in a government owned system, or a contractor owned system that's supporting DoD is secure. We use the process to validate that the System security level is at a C-2 level of trust.

We also reinstitute the DITSCAP requirement every

three years, or when there have been significant changes to the security posture of the system.

Some of the things that would require a significant change would be like hardware and software changes, upgrades, operating systems, things of that nature.

We have three main authorities the DoD has instituted that supports the DITSCAP requirement. The first one is the Department of Defense security requirements for automated information systems, or the DoD directive 5200.28.

Another one is the Department of Defense DITSCAP requirement, which is instruction 5200.40 and also the DITSCAP application manual, which is the 8510.1-M, that's the application manual for DITSCAP.

Through the process of DITSCAP, the first thing we need to do is identify the system security requirements. We look at the architecture of the system, the mission of the system, and we try to identify and document any threats that we identify that may affect the system. And also identify resources that we're going to need to complete the DITSCAP process.

We also perform a risk assessment of the system. This is where we verify that the system has the security requirements in place to support the system needs for security.

We also mitigate risks. Any risks that are identified during the risk assessment are mitigated to ensure that the security posture of the system is safe.

Next, we certify and accredit. This is where you actually get your authority to operate, or your interim authority to operate, which is signed by the designated approving authority. But we don't stop there.

We also have a post reaccreditation process, or a post validation or monitoring process, where you insure that the security posture that you have validated stays in place throughout the life cycle of that system.

Here are a few of the things that we use to insure that the security posture is in place correctly. We look at how you have your, say, discretionary access controls implemented. I won't go through this entire list, but I'll pick out some of the things that are a main interest to the DoD.

We will look at that to see how you actually or provide access all the way down to the individual user level.

We will also look at authentication and identification. Here we're trying to make sure that the system knows exactly who's using it and what objects you have or what

missions you have on that system.

We look at how the system audits users or transactions that are going on in the system. For example, when you log into a system, you go in to modify a file or a record, we want to make sure that the system keeps a record of that modification, so if required, later on, you can go back and look and see who did the modification, what was actually modified, date and time of that modification. Those are the type of things we're looking at when we look at the audit for DITSCAP.

Another important thing to consider is security testing. That's where we come out and validate that the information you have documented in your system security documentation, is in fact what is actually happening in the system. That is to prove that the system is actually functioning as it is documented.

There are three key players in the DITSCAP process. The first is identified as, for us, the MHS information assurance team. What we would do is, come out -- we are basically like the coordinators of the DITSCAP process.

We'll try to help you insure that the security documentation you developed is correct and has all the components required to insure that the documentation is

correct.

We also assist you in the development of your security requirements. We perform risk assessments. As I mentioned before, we will come out and assess the risks identified in your system or associated with your system.

And we also provide validation and recommendation to the designated approving authority as to the security posture of your system. Then we try and make sure we don't duplicate any efforts, if possible, while we're going through this process.

The system owner is also a very important component of this responsibility area for DITSCAP. The system owner is responsible for compliance with the DoD security requirements, as well as coordinating with the DAA and the IA team, concerning the CNA reviews and efforts that are going on with the system.

Also the system owner is responsible for mitigating security deficiencies that are identified during the testing process. And also to insure that any information assurance vulnerability alerts that are identified are disseminated throughout the environment.

The designated approving authority is basically the signature authority that actually will grant the ATO, which is

the authority to operate, or the IATO, which is the interim authority to operate, based on recommendations that he will receive from the certifying authority, or from the CA MHS IA team.

He will issue the accreditation statement. He would insure that the safeguards are in place, and approve mitigation strategies, and he will also insure the re-accreditation of the system is completed, as required.

MHS CNA team will come out to your site and perform three visits. The first visit will start off with the DITSCAP Kick-off Meeting, where we will identify the process of DITSCAP, identify everything we plan to do in this process, and answer any questions you have concerning the process.

We'll give you all of your other DITSCAP. We'll also explain DITSCAP implementation strategies that we have to deploy, and we will also share technologies that we have that we use in the testing process with you, such as ISS security scan software.

We will initiate reviews of your existing security and systems posture and documentation, and we will also provide guidelines for the development of the process.

The second visit, we will come out and validate the documentation that was developed. We will also execute the

security testing, and we will provide an outbrief identifying any vulnerabilities that were identified during the testing process, as well as provide recommendations for mitigation solutions.

On the final visit, we will come out and again assess the network. We will perform a risk assessment to make sure that any vulnerabilities that were mitigated are correct in place, and functioning properly.

We will also give you finalizations of the test results that we receive at that time, and then we will give you a final review of the documentation that you've developed for your DITSCAP process.

The implementation of DITSCAP insured the security posture of the DoD infrastructure, and the protection of the patient information that you manage.

And I'll go on into the ADP requirement next, and at the end, we can answer questions.

I'd like to give you a little overview of the categories for ADP. Most of us are used to hearing the term, Automated Data Processing, which is ADP. There is a current policy being developed that's changing that terminology to IT, which is basically the same thing. Just a term change. And we'll refer to it both ways here.

DoD requires background checks to insure personnel accessing DoD systems are trustworthy. It requires a security validation and investigation on individuals who access the electronic patient information. It applies to DoD civilians, contractors, and military.

The process includes, the first step will be the contractor will review the personnel or the application or resume that they've received on the applicant, and determine the category, whether this person will fall into a category 1, 2, or 3. And I'll go into more detail on those categories in a minute.

The personnel will then fill out a background investigation form. And this is normally the SF85P or the SF86P.

Then the contractor would submit that form to the government. The government would review the form, provide the appropriate background check, and then make a determination, which will be sent back to the contractor.

The contractor will maintain records of that investigation and make those records available for TMA contracting officials, who will come out and perform periodic ADP reviews to insure that the compliance is there.

The next slide actually gives you the definitions of

the three categories, which is ADP Level 1, which is sensitive positions, critical sensitive position. ADP Level 1 will be a person who is actually implementing your security program, and who also have planning, direction and design operation or oversight over the maintenance of your system.

ADP Level 1 is the highest category of a background investigation. And that's normally the most costly and the most time consuming. And I'll give you more information on that as well.

The next category is ADP Level 2, which is non-sensitive positions. This person is normally responsible for maintaining your computer system, but their work is always managed and overseen by ADP Level 1 person.

The last category are for most of the employees that we have within DoD, which is ADP Level 3. That is everyone who does not fall into ADP Level 1 or 2 categories.

Are there any question? Hi, Jack.

MALE VOICE: Hi, Dorothy. He's back. Just a couple questions, and I don't really expect an answer today, okay?

MS. WILLIAMS: Okay.

MALE VOICE: But I'll throw them out there. Under the TSM -- I'll bring this back up, again, the addendum A, Section 11, paragraph D, component that talks about separate

systems and separate networks; the DISA requirement -- I just wanted to put that out there -- would you see any sort of change as far as TMA's interpretation of what a managed care support contractor's boundary is, as a result of this addendum?

MS. WILLIAMS: Today, I believe, TIMPO is working DISA to try to change that requirement. But right now, I can't tell you that's in place, because it is not.

MALE VOICE: Okay. So I'm just -- we should proceed as indicated?

MS. WILLIAMS: Accordingly, yes.

MALE VOICE: The next item is, would we assume once we go through the DITSCAP process, and we receive an interim approval to operate or an approval to operate, that we would have some sort of single agreement with the services? For instance -- you know where I'm going with this.

MS. WILLIAMS: Yes.

MALE VOICE: That the Air Force requires a certificate of networthiness. The Navy's got their own thing, the Marine's have their own things, and the Army, not to be outdone, has their own thing, too. So DITSCAP is kind of where you start, so that's a level playing field.

Would we anticipate anything in the future, from TMA, that would provide a one-time "You're okay?"

MS. WILLIAMS: We have an initiative that we're trying to work with the services now, but it's not in place, so I can't tell you that is going to happen. But we are working that initiative.

MALE VOICE: Okay. The next question revolves around the designated approving authority DAA. Would we assume a single DAA for a contract region?

MS. WILLIAMS: Yes. You would have a single DAA for all the managed care support contractors that will be designated by TMA.

MALE VOICE: Okay. So --

MS. WILLIAMS: It will be one single DAA. There will not be multiple ones.

MALE VOICE: Okay. Thank you. And documentation, for instance, like the SSAA --

MS. WILLIAMS: Mm-hmm.

MALE VOICE: -- would we assume that there would be some support from TMA, or is that something a contractor would take on their own, that they would have to do all the documentation required?

MS. WILLIAMS: Yes. Under this contract, the contractor will have to develop the documentation. But of course, we're right there to hold your hand and help you

through the process.

MALE VOICE: Right.

MS. WILLIAMS: We have templates that we can provide to you. And we'll help you through that process. You don't have to do that alone, but you are responsible for developing the documentation.

MALE VOICE: And you've been great as we've been going through this process.

MS. WILLIAMS: Thank you.

MALE VOICE: So I understand it. I'm just asking for the future.

MS. WILLIAMS: Okay.

MALE VOICE: And then the last question I have on the subject is, would the contractor -- and I suppose a "yes" on this -- would the contractor be responsible to manage the status of the employee, once they've gone through the national agency check, or whatever the background is.

For instance, they commit some misdemeanor that all of a sudden would disqualify them from using a government system, but in no way throws them out as an employee. Would the contractor be responsible for maintaining some sort of status on all the employees that touch a government system?

MS. WILLIAMS: Yes.

MALE VOICE: Okay. Thank you.

MS. WILLIAMS: Any other questions? Everybody's tired? Ready to go? Okay. Thanks for your time.

MR. REARDON: Thank you very much, Dorothy. Well, that concludes the presentations for the afternoon. First of all, let me thank all of the briefers, the presenters, the people who supported us on the computers, and all the hard work that went into the preparation. I think you all did a great job. And I certainly appreciate your efforts.

I'd like to thank our senior leadership for sticking with us for the afternoon, and staying in the front row, and not walking out on us.

But I think especially, and more particularly, I'd like to thank each of you for coming today, spending the amount of time that you have, giving us your attention, asking great questions, because I think the questions really help us crystallize our thoughts on T-NEX, and help us to move forward with that.

And we'll look forward to additional questions that you may have in the future, if there's any way we can help you with those. There's a process set up by John to get those questions onto the web, and we'll answer them as rapidly as we can.

And as John said, before we came from a break an hour or so ago, that the briefings that you had today will be posted on the web. And let me ask John Meeker if he has any closing comments or thoughts? Okay.

Well, thank you all very much. We appreciate all of your help and your attention. Thanks a lot.

[Tricare T-NEX Information Technology (IT) Briefing concluded.)

C E R T I F I C A T E

STATE OF COLORADO)
) ss
COUNTY OF ARAPAHOE)

I, Laura M. Machen, an independent transcriber and notary public within and for the State of Colorado, certify the foregoing transcript of the tape recorded proceedings, **In Re: Tricare T-NEX Information Technology (IT) Briefing, October 3, 2002**, and as further set forth on page one, is reduced by computer transcription, and dependent upon recording clarity, is true and accurate, with special exceptions of precise identification of any or all speakers and/or correct spelling of any given or spoken proper name or acronym.

Dated this 7th day of October, 2002.

My commission expires May 23, 2004.

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